

# Analysis of the Coordination of Benefits Between Medicare and Qualified Health Plans Purchased Through American Health Benefit Exchanges and the Small Business Health Options Program

By Marcia M. Schiff

Medicare provides federal health insurance to individuals 65 years of age or older and to disabled individuals under 65 years of age. Some Medicare beneficiaries have additional health insurance coverage from a variety of sources such as an employer group health plan, a retiree plan or Medicaid. When there is more than one potential payer of a claim, coordination of benefit rules establish which coverage pays first on a claim. To understand how Medicare coordinates with Qualified Health Plans (QHPs) available through the Exchanges, a few initial questions must be examined: Can Medicare beneficiaries enroll in Qualified Health Plans purchased through the American Health Benefit Exchanges or the Small Health Option Program Exchange? What is “minimum essential coverage”? When is a Medicare beneficiary deemed to have “minimum essential coverage”? Is it based on Medicare eligibility, enrollment or both? Is enrollment in QHPs cost effective for Medicare beneficiaries? Is enrollment in such plans beneficial or detrimental to Medicare beneficiaries?

As of 2014, every individual (citizen, national, non-citizen lawfully in the country who is not incarcerated) who meet residency requirements must have “minimum essential coverage.” If such an individual does not have “minimum essential coverage” and he or she is not exempt from the requirement, he or she will face a federal penalty. The Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010 by President Obama creates state-based exchanges. When a state opts not to create a state-based exchange or enter into a state-federal partnership exchange then a solely federally facilitated health insurance exchange will be established. The health insurance exchanges (state-based, partnership or federally facilitated) provide a marketplace for individuals through American Health Benefit Exchanges (AHBEs) and a marketplace for small businesses through the Small Business Health Options Program (SHOP) to obtain coverage and avoid the imposed federal penalties.<sup>1</sup>

Beginning on October 1, 2013, individuals and small businesses can enroll in Qualified Health Plans through the Exchanges. There are new laws and regulations streamlining the enrollment process and implementing these plans and the Exchanges. As such it is important to understand how these new laws and regulations impact Medicare and the coordination of its benefits with the Qualified Health Plans available through the Exchanges.

While having health coverage is mandatory, use of the Health Insurance Exchanges to purchase health insurance

is voluntary. Individuals and businesses can opt to purchase health coverage outside of the AHBEs or the SHOP. To assist individuals and to encourage businesses to obtain and provide health insurance through the AHBEs or the SHOP, there will be incentives for them through advance payment of tax credits and cost sharing subsidies to purchase Qualified Health Plans (QHPs).<sup>2</sup> Advance payment of tax credits and cost sharing subsidies are only available to individuals enrolled in QHPs through an Exchange and to individuals not eligible for “minimum essential coverage.”

“Minimum essential coverage” includes coverage under government-sponsored programs such as Medicare.<sup>3</sup> Originally, regulations deemed that a person aging into Medicare would be eligible for government-sponsored “minimum essential coverage” when requirements for coverage under the program are met. Actual enrollment in the program was not necessary. Individuals who age into Medicare have a seven-month initial enrollment period which begins three months before they turn 65, includes the month they turn 65 and terminates three months after they turn 65. The originally proposed regulations cut short the seven-month initial enrollment period provided to Medicare eligible individuals aging into Medicare by deeming such individuals as eligible for “minimum essential coverage” on the first day of the first full month after the individual turned 65 years of age.

To resolve this problem, it was subsequently decided that an individual is deemed eligible for “minimum eligible coverage” for the purposes of the premium tax credit only if the individual is enrolled in the coverage. Failing to enroll, he or she will be deemed eligible for “minimum eligible coverage” on the first day of the fourth full month after the event establishing eligibility. In this way the final regulations took into account the seven-month initial Medicare enrollment period. This change allows individuals to enroll anytime during the seven-month initial enrollment period, including the last three months after their 65th birthday and not risk losing their tax incentives until their seven-month initial enrollment period ended or until they enrolled in Medicare, whichever comes first.<sup>4</sup> However, under the revised rule, if a person fails to enroll in Medicare during the seven-month initial enrollment period by the first day of the fourth month following his or her 65th birthday, he or she will face a lapse in coverage or a high cost QHP. This person will lose premium tax credits for a QHP purchased through an Exchange since he or she will be deemed to be eligible for “minimum essential coverage” and he or she will be in-

eligible to enroll in Medicare until the General Enrollment Period because he or she missed the seven-month initial enrollment period.

The Treasury Department and the IRS have published additional guidance, explaining when or if an individual becomes “eligible for government-sponsored minimum essential coverage” when the eligibility for that coverage is a result of a particular illness or disease.<sup>5</sup> In the case where an individual become eligible for Medicare based on illness or disease, an individual will *not* be considered to have “minimum essential coverage” until a favorable determination of eligibility has been reached by the responsible agency. Until this determination is reached the individual will be able to continue receiving tax incentives. Additionally, the Department of Treasury and the Internal Revenue Service acknowledge that there is an issue regarding individuals who do not qualify for free Medicare Part A based on their work history and as such must pay a high Part A premium. If these individuals are deemed enrolled and meeting “minimum essential coverage” requirements under the above referenced rules applying to age eligibility, they will face a great hardship. This population will forgo subsidized qualified health coverage for high cost Medicare coverage. The Department of Treasury and Internal Revenue Service are considering this issue and request comments from the public.

## Medicare and QHPs from American Health Benefit Exchanges

The issue surrounding the Coordination of Benefits between Medicare and Qualified Health Plans pertains not so much to eligibility but to the affordability and the benefits of purchasing a Qualified Health Plan through an American Health Benefit Exchange. Individuals over 65 are not excluded from purchasing a Qualified Health Plan through the American Health Benefit Exchanges. A Qualified Health Plan cannot “design benefits or reimbursement in a way that discriminates against individuals because of their age, disability, or expected length of life.” However, a QHP may charge older people up to three times more than younger ones.<sup>6</sup>

While Medicare beneficiaries will not face penalties under ACA as of 2014, as previously cited, many will be ineligible for tax incentives and cost-sharing subsidies offered for purchases of QHPs made through the American Health Benefit Exchanges.<sup>7</sup> Without tax incentives and cost-sharing subsidies Medicare beneficiaries face the possibility that a Qualified Health Plan purchased through an American Health Benefit Exchange will cost more than the combined premiums of Medicare Part B, Medicare Part D and a Medigap policy or even the cost of a Medicare Advantage Plan. As such an individual QHP could be more expensive than Medicare coverage. This is especially true for Medicare beneficiaries who may qualify for assistance through the Medicare Savings and/or the Extra Help Programs. Note that an exception to this cost-based analysis may ap-

ply to the Medicare eligible individual who must pay for a Medicare Part A premium in addition to other Medicare premiums. For this person, the purchase of a QHP through an Exchange may be a less expensive alternative, especially if the Department of Treasury and the IRS decide such a person can retain tax incentives. A further cost-based analysis of this issue can be performed when new guidelines are established and the premiums for the QHPs are published.

Besides extra expense, Medicare beneficiaries may be hurt by purchasing a QHP through an American Health Benefit Exchange. Medicare beneficiaries will not be able to purchase Medigap, Medicare Advantage Plans or Medicare Part D coverage through the American Health Benefit Exchanges. Generally, Medicare beneficiaries must enroll in Part B during their seven-month initial enrollment period to avoid a late enrollment penalty. Delaying Part B enrollment in lieu of an individual Qualified Health Plan (QHP) could subject the Medicare beneficiary to a 10% Part B premium penalty for every twelve months he or she delays enrollment. If an individual decides to enroll in Part B later he or she must do so during the General Enrollment Period from January to March each year with coverage beginning six months after enrollment (unless he or she qualifies for a Special Enrollment Period). As such a Medicare beneficiary who delays Part B enrollment in lieu of a QHP may face a lapse in coverage.<sup>8</sup>

Delaying Part D enrollment in lieu of a QHP could also subject the Medicare beneficiary to a Part D premium penalty of 1% of the national base beneficiary premium for every month the Medicare eligible individual delays enrollment. To avoid the Part D premium penalty, a Medicare eligible individual must maintain creditable coverage for at least 63 days or more. However, there is no determination yet on whether or not prescription drug coverage provided by QHPs purchased through the American Health Benefit Exchange or the SHOP is considered creditable coverage. Therefore, it is imperative that a person who becomes Medicare eligible promptly enroll in a Part D plan as well.

Medicare beneficiaries can buy separate long term care or dental coverage from Exchanges to supplement Medicare; however, there are no subsidies or advance payment of tax credits available for these purchases.<sup>9</sup> No issues of Coordination of Benefits apply between Medicare and long term care or dental policies since these policies offer benefits that are not offered by Medicare.

## Medicare and QHPs from the Small Business Health Operation Program (SHOP)

Prior to 2016 states can limit exchanges to businesses with 50 or fewer workers. Starting in 2017 states can allow businesses with over 100 employees to purchase QHPs from the SHOP.<sup>10</sup> This provides the Exchanges and QHPs time to establish themselves before additional applicants are added to the risk pool. This staggered timeline especially impacts the Coordination of Benefits for disabled workers as will be discussed below. It also prevents busi-

nesses from terminating their health coverage and sending their workers individually to the American Health Benefit Exchanges for coverage. As such, small businesses in New York can buy health insurance coverage for its employees through the Small Business Health Options Program (SHOP) Exchange. Such businesses can also take advantage of a Small Business Health Care Tax Credit if they qualify.

## Current Employees

When an employee with coverage from a QHP purchased through the SHOP becomes Medicare eligible, the coordination of his or her benefits works as any employer provided health insurance works. It would be a violation of the federal Age Discrimination in Employment Act (ADEA) for a business to drop an employee who continues to work past age 65 from his or her employer's group health plan.<sup>11</sup> Businesses are also prohibited under the Medicare Secondary Payer Rules from reducing current employees' health benefits due to their reaching the Medicare-eligible age of 65. Exceptions to these rules apply for certain small businesses. As such coverage for current employees over age 65 may be coordinated with Medicare and if that group health plan is a QHP purchased from the SHOP, that also may be coordinated with Medicare following Medicare Secondary Payer Rules.

In general, the Coordination of Benefits depends on the number of employees in the company and whether the employee or spouse, if covered under the spouse's employee health plan, is working, retired or disabled.

If the individual is 65 years of age or older, and is working for a company with less than 20 employees, Medicare provides primary coverage and the QHP provides secondary coverage.

If the individual is 65 years of age or older, and is working for a company with 20 or more employees, the QHP provides primary coverage and Medicare provides secondary coverage.

If the individual is disabled and is working for a company with less than 100 employees, Medicare provides primary coverage and the QHP provides secondary coverage.

If an individual is disabled and is working for a company with 100 or more employees, than the employer's group plan provides primary coverage and Medicare is secondary.

Note: The ACA penalizes large companies that do not offer health insurance if any of their full-time employees enroll in exchange plans and receive premium credits.<sup>12</sup> Further, New York is one of the states that have decided to limit its Exchange to businesses with 50 or fewer workers. As such, employers with over 50 employees in New York cannot purchase QHPs through the Exchange until 2016 when companies with up to 100 employees can purchase QHPs through the SHOP. As such until 2016, a disabled

worker's primary insurance coverage will not be from a QHP purchased from the SHOP. Employee coverage can be from either a self-insured group plan or one purchased from the private market assuming the company offers health insurance, and if so Medicare will provide secondary coverage. In 2017 when companies with 100 or more employees can purchase QHPs through the SHOP, then the QHP will provide primary coverage for disabled individuals and Medicare will provide secondary coverage.<sup>13</sup>

## Retired Employees

In situations regarding retired employees, different rules apply to the Coordination of Benefits between Medicare and a Qualified Health Plan purchased through the SHOP. Normally, in this situation the Coordination of Benefits depends on the worker's age at retirement and not the size of the company. Medicare provides primary coverage for retirees 65 years of age or older and the individual's retiree plan provides secondary coverage.

As stated earlier, the ACA penalizes large companies who do not offer health insurance if any of their full time employees enroll in exchange plans and receive premium credits.<sup>14</sup> However, when dealing with retirees under the Medicare age of 65, exceptions have been made for large companies. This exception has been made to eliminate the "early retiree" dilemma. When an employer does not offer retiree coverage, many individuals who are under 65 years of age and either choose to retire or are forced into retirement due to prolonged unemployment face many years without health insurance coverage until they reach the Medicare eligible age of 65. The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides coverage to employees upon a qualifying event which can include retirees.<sup>15</sup> However, this coverage is expensive and only provides health insurance coverage for up to 36 months, leaving many early retirees unable to afford or obtain adequate health insurance to cover their gap in coverage.

To alleviate the "early retirement" dilemma, the ACA allows such individuals to purchase QHPs through the American Health Benefit Exchanges with tax incentives and subsidies, if they qualify. This provides early retirees with affordable health care coverage until they become Medicare eligible. For these early retirees, the QHP will be their total coverage. Once retirees become Medicare eligible they can no longer purchase coverage through the Exchange. Nor would they want to continue purchasing health insurance from the exchange since any tax incentives and subsidies for which they qualify would terminate upon their eligibility for Medicare, making the cost of QHPs prohibitive. As such, once they become Medicare eligible, they will be treated as retirees 65 years of age or older with Medicare becoming their coverage.

Qualified Health Plans (QHP) do not automatically terminate upon Medicare eligibility. The QHP must be provided with "reasonable notice" as to the termination of coverage. "Reasonable notice" has been set as 14 days or more.

If the QHP is provided with reasonable notice, the Medicare beneficiary can choose a specific termination date for the policy.<sup>16</sup> If the QHP is not provided with “reasonable notice,” termination of coverage under the QHP will not be effective until fourteen days after the request for termination is made by the enrollee.<sup>17</sup>

There are many benefits for a Medicare beneficiary in designating a specific termination date. First, by choosing a specific termination date the Medicare beneficiary is able to obtain a safe harbor for the tax benefits, allowing him or her to enroll in Medicare anytime during their initial 7 month enrollment period without losing the tax incentives and subsidies attached to the QHP. Second, by choosing a specific termination date the Medicare beneficiary can coordinate the start of Medicare coverage and the termination of his or her QHP, thereby avoiding a lapse in coverage.

There are many disadvantages for a Medicare beneficiary who does not provide “reasonable notice.” First, without providing reasonable notice the Medicare beneficiary may need to wait two weeks before the termination of one’s QHP is effective. As such, if not timed correctly, the Medicare beneficiary can find herself enrolled in both a QHP and in Medicare resulting in the termination of tax incentives and subsidies but continuation of coverage. It is imperative for the Medicare beneficiary to disenroll from a QHP prior to obtaining Medicare coverage since the triggered loss of tax incentives and subsidies will result in higher premium bills from the QHP. Second, without providing “reasonable notice” the Medicare beneficiary risks losing QHP coverage before his or her Medicare coverage becomes effective, leaving him or her with a lapse in coverage.

Applicants looking to obtain QHPs in AHBEs will be screened for Medicare, CHIP and Medicaid. Those newly eligible for Medicare will not be referred to a QHP but will be referred to apply to Medicare for health insurance coverage.

Understanding how Medicare will coordinate with the Qualified Health Plans purchased through the American Health Benefit Exchanges and the Small Business Health Options Programs is extremely important in order to make sure that those with Medicare retain coverage and avoid extra expense due to late enrollment penalties and reduced tax incentives and subsidies. The implementation of the Health Care and Education Reconciliation Act of 2010 and the Patient Protection and Affordable Care Act is an ongoing process. Additionally, changes in the law will affect how the Coordination of Benefits between Medicare and QHPs are applied. For example, the U.S. Supreme Court recently struck down the Defense of Marriage Act.<sup>18</sup> Since Medicare is a federally sponsored benefit, the coordination of those benefits (if covered under spouse’s employee plan) must be applied to same-sex spouses as it is currently applied to heterosexual spouses. As such, regular updates on this subject are necessary in order to keep up with the changes that will occur.

## Endnotes

1. 45 CFR 1.155.100 2013, 45 CFR 1.155.140 2013, 45 CFR 1.155.700 2013.
2. Eligible Individuals and families with incomes between 138 percent and 400 percent of Federal Poverty Level are eligible for premium tax credits. Additionally, those who have lived in the U.S. for less than five years with incomes between 100% and 138% of the Federal Poverty Level may also be eligible for subsidies. In addition to premium credits, the Affordable Care Act establishes cost-sharing subsidies for eligible individuals. Act of Mar. 23, 2010, Pub. L. No. 111-148, Stat.119 as modified by Act of Mar. 30, 2010, Pub. L. No. 111-152, 124 Stat. 1029.
3. 26 U.S.C. § 5000A(f)(1)(A)(i) (2011).
4. 26 CFR Parts 1 and 602 (2012). Note different rules apply for those who qualify for Medicare based on ESRD.
5. See 26 CFR Part 601.601(d)(2) (2012); Department of Treasury and IRS Notice 2013-41 (June 2, 2013).
6. Julie Appleby, “A Guide to Health Insurance Exchanges,” Paper prepared for Kaiser Health News, January 2013. p. 1.
7. The Patient Protection and Affordable Care Act provides that premium tax credits and related subsidies are terminated automatically upon Medicare eligibility and or enrollment. 42 U.S.C § 18001 (Act of Mar. 23, 2010, Pub. L. No. 111-148, Stat. 119 as modified by Act of Mar. 30, 2010, Pub. L. No. 111-152, 124 Stat.1029; Health Insurance Premium Tax Credit 76 FR 50933-4, August 17, 2011, 76 FR 50941, August 17, 2011. See 26 CFR Part 601.601(d)(2) (2012); Department of Treasury and IRS Notice 2013-41 (June 2, 2013). As such, Medicare beneficiaries with free Medicare Part A coverage will not be required and will have no incentive to purchase QHPs through American Health Benefit Exchanges.
8. Leaving a QHP will not automatically provide you with a Special Enrollment Period unless you were accidentally or fraudulently enrolled in the plan. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule 77 Fed. Reg. 18390 (to be codified at 42 CFR 4.1455.420 2013).
9. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule 77 FR 18411 (to be codified at 42 CFR 4.155.1065 2013).
10. [http://www.whitehouse.gov/files/documents/health\\_reform\\_for\\_small\\_businesses.pdf](http://www.whitehouse.gov/files/documents/health_reform_for_small_businesses.pdf).
11. Age Discrimination in Employment (29 U.S.C. § 623).
12. On July 2, 2013, it was announced that the requirement that businesses with 50 or more provide health insurance to their workers or pay a penalty will be delayed until 2015, <http://m.usatoday.com/article/news/2484623>. As such it is questionable if businesses with 50 employees will participate in the SHOP.
13. [http://www.whitehouse.gov/files/documents/health\\_reform\\_for\\_small\\_businesses.pdf](http://www.whitehouse.gov/files/documents/health_reform_for_small_businesses.pdf).
14. *Id.*
15. The original health continuation provisions were contained in Title X of COBRA (Act of April 7, 1986, Pub. L. No. 99-272, 100 Stat. 82).
16. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule, 77 FR 18371-18374, 18394, 18395, 18463 (to be codified at 45 CFR 4.155.330 2012 and 45 CFR 4.155.430 2012); Health Insurance Premium Tax Credit, 76 FR 50933, 50934, 50941.
17. *Id.*
18. *United States v. Windsor*, 570 U.S. \_\_\_ (2013), 2013 U.S. LEXIS 4935.

**Marcia M. Schiff is an experienced health law attorney. A graduate of Hofstra University, School of Law. Ms. Schiff has devoted her career to assisting underserved populations through her work for the New York State Senate and various non-profit organizations.**

**Like what you’re reading? To regularly receive issues of the *Health Law Journal*, join NYSBA’s Health Law Section (attorneys only).**