



May 24, 2023

Benefit Coordination and Medicare Eligibility

On April 28, 2016, the Centers for Medicare & Medicaid Services (CMS) issued updates to Frequently Asked Questions Regarding Medicare and the Marketplace.¹ The 2016 FAQs added D7-9 to clarify the benefit coordination between Medicare and certain types of employer-based coverage. Specifically, in D7 of the 2016 FAQs, CMS clarified that pursuant to the essential health benefits (EHB) and actuarial value (AV) requirements under the Affordable Care Act, a health insurance issuer offering non-grandfathered health insurance coverage in the small group market (including a Small Business Health Options Program (SHOP) QHP)) may not change the plan payment level or refuse to pay for otherwise covered services on the basis that an individual is eligible for Medicare due to age but isn't actually enrolled in Medicare. The FAQ also clarified that modifying a benefit design based on Medicare eligibility could be considered discriminatory in violation of federal non-discrimination prohibitions.

The following FAQ clarifies that these Affordable Care Act requirements apply in the same manner to non-grandfathered individual health insurance coverage.

Q: An individual is enrolled in non-grandfathered individual health insurance coverage and is eligible for Medicare but isn't enrolled in Medicare. May the issuer change the payment level for or refuse to pay for covered services for which Medicare would have paid had the person been enrolled in Medicare?

No. In the absence of enrollment in other primary coverage (such as Medicare), an issuer offering non-grandfathered (non-grandmothered)² individual health insurance coverage cannot take that other coverage into account when paying for covered services. Pursuant to the EHB and AV requirements under the Affordable Care Act,³ an issuer offering non-grandfathered individual health insurance coverage may not limit or exclude coverage based on the theoretical possibility of an individual's enrollment in other coverage.⁴ Additionally, modifying a benefit design based on an

¹ Centers for Medicare & Medicaid Services, Frequently Asked Questions Regarding Medicare and the Marketplace (updated Apr. 28, 2016), available at https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_4-28-16_v2.pdf.

² "Grandmothered" coverage refers to coverage offered consistent with the Limited Non-Enforcement Policy last extended on March 23, 2022. See Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, Extension of Limited Non-Enforcement Policy through 2023 and Later Benefit Years (Mar. 23, 2022), available at <https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf>.

³ Affordable Care Act § 1302; Public Health Service Act § 2707; 45 CFR 147.150; 45 CFR part 156, subpart B.

⁴ This is true regardless of whether an individual is (or is presumed) eligible for Medicare on the basis of age, disability, or end-stage renal disease but not actually enrolled in Medicare.

individual's eligibility for Medicare could be considered as violating federal non-discrimination prohibitions.⁵ Therefore, non-grandfathered (non-grandmothered) individual health insurance coverage must pay for covered services for an enrollee who is (or is presumed) eligible for but not enrolled in other primary coverage, without taking that other coverage into account.

We remind issuers that under regulations implementing the Public Health Service Act's guaranteed renewability of coverage requirements, Medicare entitlement or enrollment is not a basis to nonrenew an individual's health insurance coverage in the individual market when the renewal is effectuated under the same policy or contract of insurance.⁶

⁵ Non-discrimination provisions that may apply to non-grandfathered individual health insurance coverage, among others, include those in the guaranteed availability regulation (45 CFR 147.104(e)); the essential health benefits regulations (45 CFR 156.125); and, with respect to individual market QHPs, the QHP certification standards (45 CFR 156.200(e)), as applicable.

⁶ 45 CFR 147.106(h)(2); 81 FR 94058, 94067-8 (Dec. 22, 2016).