

How Do the Medicare Rules Impact Employer-Sponsored Health Plans?

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Agenda

- Basic overview of Medicare Part A and Part B;
- Explanation of the Medicare Secondary Payer rules;
- The interaction between Medicare and HSA eligibility; and
- Explanation of COBRA qualifying events related to Medicare, and how they impact COBRA coverage.

Why This Topic?!

- We have noted that many employers have older workers who are nearing retirement
- Benefit departments are being asked more questions about Medicare and the impact on group health plans—especially from retiring executives
- Benefit professionals at companies should understand how Medicare and the group health plan interact
- However, there are many Medicare issues that are unrelated to an employer-sponsored plan or any obligation related to the employer
 - In that case, stick to a high-level explanation and direct them to written materials (such as government websites)
 - Just as an employer should not provide an employee with personal tax advice, an employer should not advise an employee on how/when to enroll in Medicare

Basic overview of Medicare Part A and Part B

Basic Overview

- Medicare was created on in 1965, by President Lyndon B. Johnson to guarantee health insurance for elderly Americans. Prior to the program, nearly half of all seniors lacked health coverage because private insurance was either unavailable or prohibitively expensive
- Medicare is divided into three main parts: Parts A, B, and D
- Part A is the hospital insurance program and generally covers hospital care, skilled nursing facility care, hospice, and home health services
- Part B covers physicians' services (e.g., office visits), preventive care and certain other health care expenses, such as expenses associated with durable medical equipment and mental health services
- Part D (which became effective in 2006) covers certain prescription drug expenses
- Individuals who are entitled to Medicare Parts A and B may be eligible for the Medicare Advantage program under Medicare Part C, which is often comprised of Part A and Part B benefits and may also include Part D prescription drug benefits and vision/dental
- This presentation is focused on Part A and Part B

Basic Overview—Eligibility

- Medicare is the federal health insurance program for:
 - People who are 65 or older
 - Certain people younger than 65 with disabilities
 - People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)
- For purposes of Medicare, the term “entitlement” means that an individual is eligible for AND enrolled in Medicare

Basic Overview—Part A—Enrollment

- An individual is automatically entitled to Medicare Part A if they are receiving Social Security or Railroad Retirement Act retirement benefits
 - In general, Medicare Part A entitlement based on age cannot be waived by individuals who are receiving Social Security benefits
- Other individuals must file an application to become entitled to Part A benefits
- In most cases, there is no premium for Part A
- Age Based Medicare:
 - If an application is required, and if it is filed within six months after attaining age 65, then Medicare Part A entitlement is retroactive the month the individual attained age 65.
 - If the application is filed more than six months after the first month of eligibility, then Medicare Part A entitlement is retroactive—going back 6 months
- There are different rules for when Medicare entitlement is based on Disability or ESRD, which are not addressed in this program

Basic Overview—Part B—Enrollment

- Individuals who become entitled to Part A can enroll in Part B at the same time
- A premium payment is required for Part B (the amount of the premium is based on income)
- Age Based Medicare—Initial Enrollment Period:
 - There is an Initial Enrollment Period (IEP) that is seven months. It begins three months before the individual's 65th birthday, includes the month the individual turns age 65, and ends three months later
 - If an individual enrolls in Part B during the first three months prior to attaining age 65, coverage begins on the month in which they turn 65
 - For individuals who enroll during the month turn age 65, coverage begins the month after they enroll
 - Individuals who enroll during the last three months of their initial enrollment period will be covered beginning the month after enrollment
- There are similar rules for Medicare entitlement is based on Disability of ESRD, which are not addressed in this program

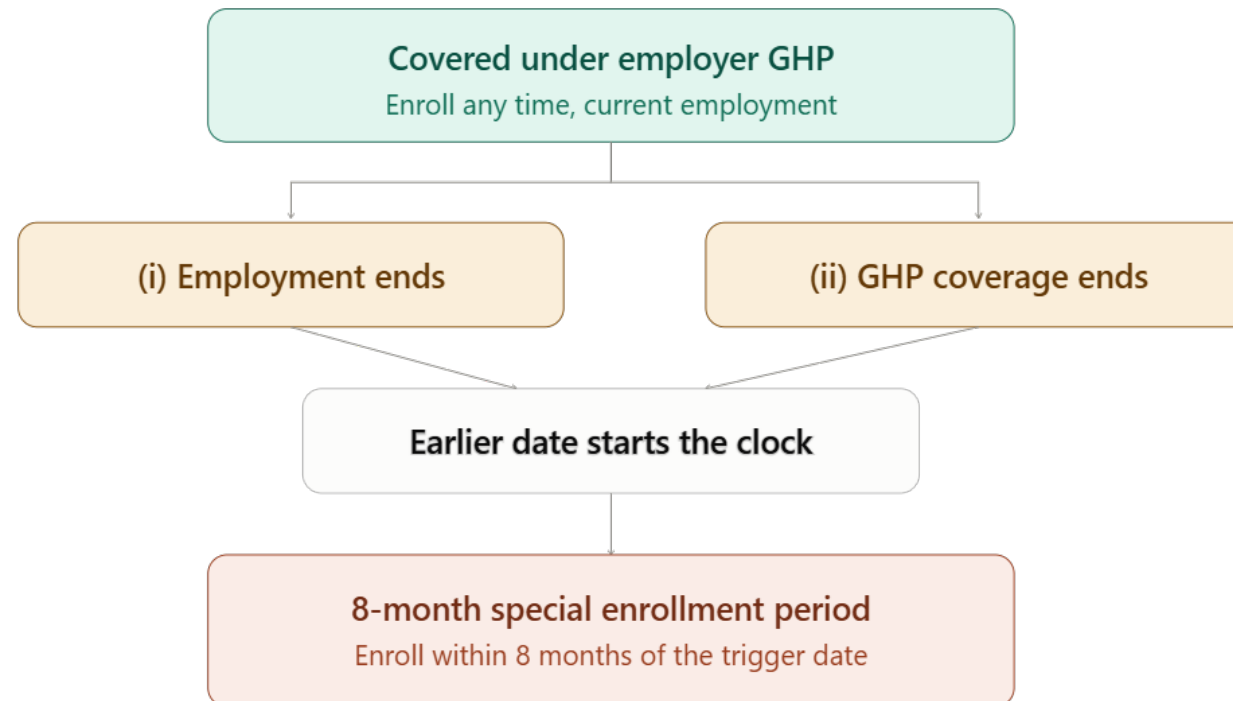
Basic Overview—Part B—Enrollment

- General Enrollment Period:
 - An individual who does not enroll during the IEP may enroll later during the general enrollment period
 - The general enrollment period runs each year from January 1 through March 31. Individuals who enroll in Part B during the general enrollment period have coverage beginning in the month after they enroll.
- Special Enrollment Period (SEP):
 - Once an individual's IEP ends, they may qualify to enroll for Medicare during a SEP
 - If an individual is continuously covered under an employer-sponsored group health plan based on his/her current employment (or the current employment of their spouse), he/she may qualify for a SEP to sign up for Part B.
 - The following doesn't count as coverage based on current employment: Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, retiree health coverage, Veterans Affairs (VA) coverage, or individual health coverage (such as through the Health Insurance Marketplace).
- An individual who meets the requirements above will have an 8-month SEP

Basic Overview—Part B—Enrollment

- For the SEP, the individual can enroll at any time while covered under the group health plan based on current employment, or during the eight-month period following the earlier of (i) the date employment ends; or (ii) the date the group health plan coverage based on current employment ends (see graphic on next slide).
- If the individual enrolls in Part B in a month **during any part** of which they are covered under a group health plan on the basis of current employment status, or in the first full month when no longer so covered, coverage begins on the first day of the month of enrollment or, at the individual's option, on the first day of any of the three following months.
- If the individual enrolls in any other month of the SEP, coverage begins on the first day of the month following the month of enrollment.

Basic Overview—Part B—Special Enrollment Period



Part B—Late Enrollment Penalty

- Individuals must pay a premium for Part B coverage
- If a person does not enroll in Part B during the Initial Enrollment Period, their Part B premiums will be subject to a lifetime penalty, unless they are eligible to enroll during the “Special Enrollment Period” described earlier
- Remember that COBRA and retiree health plans are NOT considered coverage based on current employment. An individual is NOT eligible for a Special Enrollment Period when COBRA or retiree health plan coverage ends
- The late enrollment penalty for Medicare Part B is a 10% increase in premium for each full 12-month period in which an individual could have had Part B but did not sign up for it, measured from the end of the individual’s IEP
- The late enrollment penalty is permanent

Part B—Late Enrollment Penalty

Example from Medicare.gov

- If you waited 2 full years (24 months) to sign up for Part B and didn't qualify for a Special Enrollment Period, you'll have to pay a 20% late enrollment penalty (10% for each full 12-month period that you could have signed up), plus the standard Part B monthly premium (\$202.90 in 2026).
- **2026 Calculation:**
- \$202.90 (2026 Part B standard premium)
+ \$40.58 (20% [of \$202.90] late enrollment penalty)
- Total is \$243.48
- **\$243.50 will be your Part B monthly premium for 2026.** This amount (\$243.48) is rounded to the nearest \$.10 and includes the late enrollment penalty.

Part B—Late Enrollment Penalty

- An individual does not have to pay a penalty if they sign up for Medicare Part B within eight months of losing your job-based coverage based on “current employment status” (i.e., the Special Enrollment Period). There are other exceptions, such as the following:
- Less than a year without Part B. If an individual misses their enrollment deadline but signs up during the next general enrollment and fewer than 12 full months have lapsed, that individual will not pay a penalty
- A reset of the penalty clock. If the individual is younger than 65, has Part B because of a disability and are paying Part B late penalties, that individual will no longer pay them after they turn 65. At that point, the individual becomes eligible for Medicare based on age instead of disability

Medicare Secondary Payer Rules

Basic Overview—Medicare Secondary Payer Rules

- The Medicare Secondary Payer (MSP) rules prohibit a group health plan from “taking into account” the Medicare entitlement of a current employee or a current employee's spouse or “family member.” This means that the group health plan must pay primary to Medicare (i.e., it must process and pay the claim first).
 - A family member does not include a domestic partner
- The definition of a group health plan is, “a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.”
- This is a broader definition than under ERISA. For example, it applies to church and governmental plans

Basic Overview—Medicare Secondary Payer Rules

- There are complex rule for when the MSP rules apply to a plan. This program does not describe all of the rules.
- In general, the MSP rules apply to group health plans of employers that have 20 or more employees for each working day in at least 20 weeks in either the current or the preceding calendar year. It does not matter if those employees are covered under the group health plan—they still count.
 - The term “employer” means all entities in the controlled group
 - There are different rules for multiemployer and multiple employer group health plans. In addition, there are different rules when Medicare entitlement is based on disability. These special rules are not addressed in this program.

Basic Overview—Medicare Secondary Payer Rules

- A key term is “current employment status.” That term includes:
 - An individual who is actively working as an employee
 - An individual who is not actively working if they (a) are receiving disability benefits from an employer for up to six months; or (b) retain employment rights in the industry, has not had their employment terminated, is not receiving disability benefits from an employer for more than six months or from Social Security, and has group health coverage (other than COBRA coverage)
- There are other special rules, such as for self-employed individuals, members of religious orders and members of clergy

Basic Overview—Medicare Secondary Payer Rules

- If an active employee's spouse is enrolled in Medicare and the group health plan, Medicare will pay secondary for the spouse
- However, the MSP protections do not apply to a domestic partner
- If an active employee covers a domestic partner who is enrolled in Medicare, the group health plan can pay secondary (i.e., Medicare pays primary)
 - A group health plan can also pay secondary to Medicare for any Medicare-eligible domestic partner—even if the domestic partner is not enrolled in Medicare (in that case, the plan pays as if the domestic partner was enrolled in Medicare)
- This **MUST** be clear in the plan document and the summary plan description

Basic Overview—Medicare Secondary Payer Rules

- Generally, group health plan coverage for former employees and retirees are not subject to the MSP rules
- There is a special rule for rehired retirees. A reemployed retiree who is covered by a group health plan and who performs sufficient services to qualify for coverage on that basis (that is, other employees in the same category are provided health benefits) is considered covered “by reason of current employment status” even if:
 - The employer provides the same group health plan coverage to retirees; or
 - The premiums for the plan are paid from a retirement or pension fund.

Basic Overview—Medicare Secondary Payer Rules

- There are special rules for those who are entitled to Medicare due to ESRD
- Medicare must be the secondary payer for the first 30 months of an individual's ESRD-based Medicare eligibility or entitlement, regardless of the patient's employment status
- After the 30 month “coordination period” Medicare becomes the primary payer
- These special ESRD rules apply to all employers regardless of size

Basic Overview—Medicare Secondary Payer Rules

- A group health plan may not “take into account” the age-based Medicare entitlement of an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status.
 - Similar rules apply for Medicare entitlement due to disability (different rules apply to entitlement due to ESRD)
- In addition, the plan must provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

Basic Overview—Medicare Secondary Payer Rules

- The applicable regulation includes examples of actions taken by a group health plan that constitutes “taking into account” that an individual is entitled to Medicare. Some of the actions listed are the following:
 - failure to pay group health plan benefits primary to Medicare or offering coverage that is secondary to Medicare
 - terminating coverage because the individual has become entitled to Medicare
 - imposing limitations on benefits for a Medicare entitled individual that do not apply to others enrolled in the plan
 - charging a Medicare entitled individual higher premiums
 - requiring a Medicare entitled individual to wait longer for coverage to begin
 - providing misleading or incomplete information that would have the effect of inducing a Medicare entitled individual to reject the employer plan

Basic Overview—Medicare Secondary Payer Rules

- The regulation does make it clear that a group health plan may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the plan coverage is COBRA continuation coverage because of reduced hours of work
 - In that case, Medicare is the primary payer for this beneficiary because, although the individual has current employment status, the group health plan coverage is by virtue of the COBRA law rather than by virtue of the current employment status
- While not addressed in the regulations, employers can educate their employees about Medicare and its interaction with the employer's group health plan
 - Any such education programs must not be misleading, and the employer cannot try to induce the individual to reject the employer-provided coverage.

Basic Overview—Medicare Secondary Payer Rules

- An employer cannot offer any “financial or other incentive” for an individual entitled to Medicare not to enroll in a group health plan that would otherwise be the primary plan.
- The U.S. Department of Health and Human Services (HHS), has provided some informal guidance regarding cash outs. A summary of the questions and answers are below.
- Question. An employer maintains a cafeteria plan under Internal Revenue Code (Code) Section 125 that allows employees to choose between health insurance and cash amounts. The same choices would be offered to everybody regardless of age or Medicare status. In the case of participants who are eligible for or entitled to Medicare, would the cash payments be viewed as an improper incentive for those individuals to select Medicare as their primary payer?
- Answer: As long as any cash payment to an employee is made based on the employee's election as a benefit offered under the employer's cafeteria plan, i.e., one which meets the requirements of section 125 of the Code, it would not be a violation of the Medicare law, which prohibits an employer from offering an individual entitled to Medicare any financial or other benefits as an incentive not to enroll in, or to terminate enrollment in, a GHP which would be, or is primary to Medicare.

Basic Overview—Medicare Secondary Payer Rules

- Question: Suppose the cafeteria plan requires the participant to demonstrate other coverage before he or she could elect cash. Would the answer be different?
- Answer: If the plan treats all employees the same in that those without Medicare entitlement must also show that they have other health insurance coverage before they could elect a cash payment then such cafeteria plan would not be illegally taking Medicare into account in having such a requirement

Basic Overview—Medicare Secondary Payer Rules

- If Medicare pays primary—when it should not have—the group health plan must reimburse Medicare
- If the federal government (through Centers for Medicare and Medicaid—CMS) must bring legal action to recover the payment, then it is entitled to collect twice the amount of its payment
- An action may be brought against any entity that is required or responsible to make a primary payment—which can include the employer

Basic Overview—Medicare Secondary Payer Rules

- Failure to comply with the MSP requirements may result in an excise tax being imposed on the employer equal to 25% of group health plan expenses incurred during the calendar year
- This is enforced by the IRS
- The excise tax is not based on the cost of an individual claim. Rather it is equal to 25% of the employer's total group health plan expenses for the entire calendar year

Retiree Medical

- In most cases, a retiree medical plan is not subject to the MSP rules because that plan is not covering any employee based on “current employment status”
- A retiree medical plan will generally pay secondary to Medicare for those who are entitled to Medicare
- A retiree medical plan could also state that for those who are Medicare eligible due to age, the plan will pay as if the person is enrolled in Medicare—even if they are not!
- The MSP rules in a retiree medical plan should be VERY clear

The Interaction Between Medicare and HSA Eligibility

HSA Eligibility

- Only an “eligible individual” can make contributions to a health savings account (HSA)
- An individual who is entitled to Medicare is not HSA-eligible
- In other words, individuals who are “entitled” to Medicare benefits (meaning both eligible for Medicare *AND* enrolled in Medicare) are not eligible to contribute to an HSA.
- If an individual is enrolled in either Part A or Part B of Medicare, he/she cannot contribute to an HSA
- The provisions in Medicare that make the Part A coverage retroactive can cause problems

HSA Eligibility

- Note that employees do not cease to be an eligible individual for the HSA just because they have attained age 65
- It is Medicare enrollment that causes an individual to lose HSA eligibility
- In many cases, employees age 65 and older do not enroll in Medicare if they are still actively employed
- However, remember that for anyone who is receiving Social Security retirement benefits, they are automatically enrolled in Part A (with almost no ability to opt-out of Part A coverage), and therefore automatically lose HSA eligibility

HSA Eligibility

- As discussed earlier in the presentation, in most cases, Part A is premium-free. Because it is premium-free, there is no penalty for enrolling in Part A after the Initial Enrollment Period
- An individual can sign up for premium-free Part A (if eligible) any time after their Initial Enrollment Period begins
- If an individual signs up for premium-free Part A within 6 months after their 65th birthday, Medicare Part A coverage start date will go back (retroactively) to the month the individual turned age 65
- If the individual signs up for premium-free Part A more than 6 months after attaining age 65, the Medicare Part A coverage start date will go back (retroactively) 6 months from when the individual signed up
- This retroactive effective date of coverage under Part A will cause an individual to be ineligible to contribute to an HSA for those months in which the individual has retroactive Medicare coverage

HSA Eligibility

In the examples below, assume that the employee is an eligible individual for the HSA rules and the only issue is Medicare coverage.

- **Example 1—Enroll In Medicare at Age 65:** Employee turns 62 and becomes eligible for reduced Social Security benefits, but does not apply for benefits. Employee then turns 65 and enrolls in Medicare. Employee's Medicare entitlement date is the month she turns age 65. Employee is ineligible to contribute to the HSA as of the month she attains age 65 because that is when she becomes both eligible for and enrolled in Medicare.
- **Example 2—Begins Social Security Benefits Before Age 65:** Employee turns age 63 and becomes eligible for reduced Social Security benefits. Employee applies for and receives Social Security benefits at age 63. When Employee turns age 65, she is automatically enrolled in Part A of Medicare because she is already receiving Social Security benefits. She is not eligible to contribute to the HSA as of the month she attains age 65 because she is enrolled in Part A of Medicare.

HSA Eligibility

- **Example 3—Enroll in Medicare After Age 65**: Employee turns age 62 and does not apply for Social Security benefits. Employee then turns age 65 and does not enroll in Medicare and does not apply for Social Security benefits. Employee retires at age 68 and applies for Medicare and Social Security benefits at that time, which is during her Special Enrollment Period.
- Employee's Medicare Part A entitlement is retroactively effective 6 months prior to her application for Medicare benefits, to age 67 ½, because she applied for Medicare more than 6 months after becoming initially eligible.
- Accordingly, this individual is not eligible to contribute to an HSA as of age 67 ½ because that is the date that his/her Medicare Part A benefits become effective.

HSA—Excise Tax

- When HSA contributions are made for/by an employee who is not an eligible individual, those contributions are considered “excess contributions.”
- An excise tax of 6% for each taxable year is imposed on the HSA holder for all excess contributions
- This excise tax is avoided if the excess contributions for a taxable year and the net income attributable to such excess contributions are distributed to the account holder before the last day prescribed by law for filing the account holder's federal income tax return for the taxable year (generally, the following April 15).
- The excise tax is intended to be cumulative and to continue in future years if the excess contribution is not distributed

HSA

- The employer is not obligated to find out if an employee is enrolled in Medicare when it makes contributions to an employee's HSA
- Employer contributions to an employee's HSA (including pre-tax salary reductions under a cafeteria plan) are not subject to withholding from wages for income tax or subject to FICA or FUTA if, at the time of the contribution, it is reasonable to believe that the employee will be able to exclude the payment from the employee's income
- IRS Notice 2004-50 states that an employer need only determine that an employee has HDHP coverage provided by the employer, that the employee does not have non-HDHP coverage provided by the employer, and that (for purposes of catch-up contributions) the individual is over the age of 55
- If the employee becomes an ineligible individual for the HSA rules due to these Medicare rules, the employer cannot recoup amounts from that employee's HSA. Only the employee can take the corrective action.

Explanation of COBRA Qualifying Events Related to Medicare, and How They Impact COBRA Coverage

COBRA

- For this part, the program assumes that the employer is subject to the federal COBRA laws (“COBRA”)
- COBRA requires employers to offer a COBRA election to qualified beneficiaries when there is:
 - a triggering event listed in the COBRA statute
 - that causes (or will cause) a loss of plan coverage
 - within the maximum COBRA coverage period
- When these things occur, there is a COBRA qualifying event

Medicare—Qualifying Event

- One of the “triggering events” listed in the COBRA statute is entitlement to Medicare
- The statute provides that it is a qualifying event only for the spouse and dependent children, not for the employee
- However, due to the Medicare Secondary Payer (MSP) rules, in most cases, Medicare entitlement will NOT cause a loss of coverage for group health plans covering active employees
- Hence, the entitlement to Medicare in that situation will NOT be a COBRA qualifying event
 - In that case, reference to “entitlement to Medicare” being a qualifying event should be removed from COBRA communications to participants and beneficiaries.

Medicare Entitlement & Early Termination of COBRA

- COBRA coverage may terminate early when a qualified beneficiary first becomes, after the date of the COBRA election, “entitled to benefits under title XVIII of the Social Security Act,” i.e., Medicare.
- If a qualified beneficiary's Medicare entitlement occurs after COBRA is elected, then the qualified beneficiary's COBRA coverage can be terminated. (Treas. Reg. §54.4980B-7, Q/A-3(a))
- Example #1: An individual (former employee) enrolls in COBRA coverage and subsequently becomes entitled to Medicare. Their COBRA coverage may end. Note that this will NOT affect the COBRA rights of other qualified beneficiaries in a family unit (such as a spouse or child) who are not entitled to Medicare.
- Example #2: An individual (former employee) is entitled to Medicare before electing COBRA. When he has a qualifying event (such as a loss of active group health coverage due to termination of employment) he still has the right to elect COBRA coverage. The COBRA offer cannot be withheld because of Medicare entitlement.

COBRA & Medicare

- Entitlement to Medicare could be a qualifying event for a retiree medical plan, but only for the spouse and dependent children
- As noted earlier, the MSP rules do not apply to retiree health plans—as those plans cover individuals who are not in current employment status
- Accordingly, Medicare entitlement may cause a loss of coverage for the covered retired employee (and their spouses and dependent children)
- If that happened, Medicare entitlement would constitute a first qualifying event for the affected spouse and dependent children, permitting them to elect up to 36 months of COBRA under the plan

Medicare Entitlement as a 2nd Qualifying Event

- COBRA contains a rule regarding multiple qualifying events
- The initial maximum coverage period may be extended to 36 months if certain qualifying events occur after a first qualifying event (such as termination of employment or reduction of hours, in which the COBRA period is 18 months)
- However, in most cases, entitlement to Medicare will not be considered a second qualifying event because the covered employee's Medicare entitlement would not have caused a loss of coverage under the plan due to the MSP rules
- Medicare entitlement of the covered employee will rarely be a first qualifying event because it will rarely cause a loss of plan coverage. And for the same reason, Medicare entitlement will rarely be a second qualifying event for these rules
 - In that case, reference to “entitlement to Medicare” being a second qualifying event should be removed from COBRA communications to participants and beneficiaries

COBRA & the Medicare Extension Rule

- A special rule applies when the qualifying event is a termination of employment or reduction of hours that occurs **within 18 months after** the date of the employee's Medicare entitlement
- When a covered employee's qualifying event (i.e., a termination of employment or reduction of hours) occurs within the 18-month period after the employee becomes entitled to Medicare, the employee's spouse and dependent children (but not the employee) become entitled to COBRA coverage for a maximum period that ends 36 months after the covered employee becomes entitled to Medicare
- The covered employee remains entitled to the regular 18 months of COBRA coverage after the termination of employment or reduction of hours

COBRA & Medicare

- Example #1: Adam, an employee of Company A, became entitled to Medicare on May 1, 2025. Adam retires on May 1, 2026. Adam elects COBRA for himself and his wife Mary under Company A's health plan.
 - Adam is entitled to up to 18 months of COBRA coverage from the date he retired
 - Mary is entitled to up to 24 months of COBRA coverage from the date Adam retired (24 months from Adam's termination date is the same as 36 months from Adam's Medicare entitlement date)
- Example #2: Assume the same facts as in Example 1, except that Adam retires on May 1, 2027
 - Mary is entitled only up to 18 months of COBRA coverage from the date that Adam retired, because Adam's Medicare entitlement occurred more than 18 months before the qualifying event (termination of employment).

Suggested Action Items

COBRA & Medicare

- Make sure that the active group health plan is clear about if Medicare eligibility impacts the coverage offered to a domestic partner
- Ensure that the retiree health plan is clear about how Medicare entitlement and Medicare eligibility impacts the coverage
- Consider if you should provide employees with information about how Medicare impacts HSA-eligibility
 - If you choose to do that, make sure you add caveats, such as that the document provides a general overview of how Medicare and HSA coverage interact. That the company cannot provide employees with advice on this issue. That they need to contact their personal advisor. And that they can find additional information on the Medicare website
 - This is a good document to refer employees to-- Medicare Decisions for Those Over 65 and Planning to Retire in the Next 6 Months <http://cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers-and-Unions/FS4-Medicare-for-people-over-65-nearing-retirement.pdf>
- Review your COBRA documentation (notices, SPD, etc.) to ensure that the COBRA/Medicare rules are clear. Consider adding examples.

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