

**Joint Committee on Employee Benefits Q&A
with the U.S. Health and Human Services Dept.
and Health Care Finance Agency
based on meeting with staff
May 23, 2000**

The following questions and answers are based on informal discussions between private sector representatives of the JCEB and Health and Human Services Department and Health Care Finance Agency officials. The questions were submitted by ABA members, and the responses were given at a meeting of JCEB and government representatives. The responses reflect the unofficial, individual views of the government participants as of the time of the discussion, and do not necessarily represent agency policy. This report on the discussions was prepared by designated JCEB representatives, based on the notes and recollections of the JCEB representatives at the meeting, and has not been reviewed by HHS or HCFA personnel. The questions were submitted in advance to the agency, and it was understood that this report would be made available to the public.

1. **MSP Rules under *Geissal* Case.** COBRA beneficiaries already on Medicare at the time of a COBRA election are entitled to keep both Medicare and COBRA for the full duration of the COBRA period. The following questions arise as to how the Medicare Secondary Payor rules are to be applied (some of these questions were addressed last year, but in the absence of official formal guidance we wish to keep abreast of any changes in HCFA's thinking):

- a. When the COBRA qualifying event is termination of employment, the COBRA rights relate to the employee's (and the employee's dependents') past coverage, and not to current employment status. Therefore, can we assume that Medicare will be primary in cases where the employment of the covered employee has terminated and the covered employee and/or the dependents of that employee have elected COBRA?

Proposed Answer: If the employment of the individual whose employment was the basis for the original coverage is terminated, Medicare is primary, so long as the Medicare entitlement is not on the basis of ESRD.

Actual Answer: They are hoping to issue guidance shortly, and prefer to hold comments until that is issued.

- b. We have had difficulty in getting HMOs to provide COBRA on a Medicare primary basis. Does HCFA know of any reason why it would be impermissible under the laws regulating HMOs for them to provide COBRA coverage in a manner consistent with the MSP requirements?

Actual Answer: They haven't thought about that, and cannot answer at this time.

- c. When the COBRA qualifying event is divorce, and the covered employee on whom the ex-spouse's coverage was based before the divorce continues to be employed, does the ex-spouse cease to have coverage by virtue of the employee's current employment status for MSP purposes?

Proposed Answer: Divorced spouses, like other COBRA beneficiaries, have their coverage by virtue of the COBRA statute and not by virtue of anybody's current employment status, even if the person to whom the COBRA beneficiary was previously married is still actively covered by the plan and actively employed.

Actual Answer: They prefer to defer giving a specific answer until issuance of guidance.

- d. In the case of ESRD, assuming an individual has only one continuing episode of ESRD, and also assuming the individual has no basis other than ESRD for Medicare entitlement, is it correct that the 30-month Medicare secondary period will be applied only once to the individual, regardless of whether it runs before or after the COBRA coverage period? (Presumably, the 30-month MSP period could even occur partially before and partially after the COBRA effective date.)

Proposed Answer: In the case of ESRD, the 30-month period works normally for the person and the plan, and the person's status as a regular employee or dependent or a COBRA beneficiary is irrelevant.

Actual Answer: They prefer to defer giving a specific answer until issuance of guidance.

2. **MSP and Short Term Disability Benefits.** The following questions are based on the fact scenario that many employers subsidize COBRA coverage for some period when an employee is unable to work due to disability, and such subsidies may occur whether or not the employer is paying short term disability benefits to the employee:

- a. In general, is it true that, where the employee is receiving disability payments, Medicare remains primary for the first 6 months of the disability payments?

Proposed Answer: Yes, the MSP rules continue to apply during the first 6 months of the disability benefit period, during which time the disability payments continue to be subject to FICA taxes.

Actual Answer: They agree with the proposed answer regarding disability payments by the employer to individuals (or their family members) who are subject to the working aged and working disabled MSP rules, since those individuals' coverage during that 6-month FICA/disability period is, by definition, on account of "current employment status."

- b. Suppose the only disability benefit the employee receives during that first 6 months is that the employer pays for health insurance as a subsidized COBRA benefit. Since such payments, if provided under the plan, would not be taxable to the employee, there would be no FICA tax due. Does the absence of taxable benefit payments make Medicare primary immediately upon the employee's disability, or does the employer's provision of free COBRA coverage during that 6-month period make the MSP rules continue to apply?

Proposed Answer: It is only cash disability benefits that keep the MSP rules in force for a person on disability leave. If there are no cash benefits, the mere fact that the person continues to receive tax-free employer-paid health insurance as a disability benefit will not make the employer's plan primary, since the coverage at that point is no longer on account of the individual's current employment status but rather is on account of his or her inability to work.

Actual Answer: This creates an interesting question. They have operated under the assumption, since the 5th Circuit decision in the Blue Cross/Blue Shield case, that COBRA coverage is not on account of current employment status, including during the 6-month disability period, and that an employer offering continued health coverage as a disability benefit (with or without taxable cash disability benefit payments in addition) would do so as a part of the regular health plan and not subsidized COBRA payments. We had a substantial discussion of (1) the fact that an employer could apply any period of employer-provided health coverage following the qualifying event to the COBRA period under the most recent COBRA regulations, and (2) the possibility that, if it worked to get them out of the MSP rules for the initial 6-month disability benefit period, some employers might decide to obtain the same result by simply conditioning the employer-provided health coverage on a COBRA election, to make it clearer that it was actual COBRA coverage that the employer was subsidizing. They did not have an immediate answer for whether converting what is really a health continuation disability benefit to a subsidized COBRA benefit would work to get around the MSP rules. They said they'd like to think about that possibility.

- c. During an FMLA leave, the employer is required by the Family and Medical Leave Act to provide health insurance coverage to the person on FMLA leave on the same basis as such coverage is provided to active

employees. However, the employer is not required by law to provide any form of cash disability payments to employees on FMLA leave if it does not otherwise offer disability benefits. Typically, an employee who takes the maximum FMLA leave (12 weeks), but who remains too disabled at the end of that time to return to work, is considered terminated at the end of the 12-week FMLA leave period.

Suppose a disabled employee receives 12 months of employer-paid disability benefits (taxable cash benefits), even though the employer is not required to provide such benefits, but the first 12 weeks of the 12-month disability benefit period overlap with the employee's FMLA leave. Clearly, because there is a paid disability period, the employer's plan will be primary for 6 months. Does the 6-month period in which the employer's plan is primary due to the disability payments begin at the beginning or the end of the FMLA leave period?

Proposed Answer: The employee is treated as any other active employee while on FMLA leave for health insurance purposes, so the 6-month "disability benefit" MSP period doesn't start until the end of the FMLA leave (or earlier, if the employee's employment is formally terminated at an earlier date).

Actual Answer: Not specifically answered.

3. **Cafeteria Plans.** For the last three years we have asked several questions about the interaction between the Medicare Secondary Payor laws and Cafeteria Plans under Section 125 of the Internal Revenue Code. Last year's answers appeared to differ substantially from prior year's answers, and we would like to know HCFA's current position:
 - a. Suppose an employer with a cafeteria plan under Section 125 of the Code allows employees to choose between health insurance and a cash amount equivalent to what the insurance would cost the employer under the employer's group health plan. Clearly such an option limited to those entitled to Medicare would be prohibited. But in a typical cafeteria plan the same choices would be offered to everybody regardless of age or Medicare status.
 - i. In the case of participants who are eligible for or entitled to Medicare, would the cash payment be viewed as an improper incentive for those individuals to select Medicare as their primary payor?

Proposed Answer: No. Employees on Medicare may be offered the same options as any other employee to get cash instead of the

employer's health plan pursuant to a cafeteria plan qualified under Section 125 of the Internal Revenue Code.

Actual Answer: They have been working hard on these issues for some time and are hoping to issue guidance shortly, and prefer to hold comments until that is issued.

- ii. Suppose the cafeteria plan required the participant to demonstrate other coverage before he or she could elect cash. Would the answer to i. be different?

Proposed Answer: Again, whatever the benefits and limitations are for those under age 65 should be the same for those over 65.

Actual Answer: Not specifically answered.

- iii. What if it is a choice among non-taxable benefits not covered by Section 125?

Proposed Answer: Non-125 options are fully subject to the literal application of MSP. Section 125 of the Code was specifically enacted by Congress as a benefit intended to be made available to employees. Anything legal under that provision should be legal under MSP. However, whatever results follow from more general provisions of the tax code can more easily be presumed to be overridden by the specific MSP rules enacted by Congress.

Actual Answer: Not specifically answered.

- b. Cafeteria plans often allow employees to contribute amounts out of what would otherwise be their pay to a "health flexible spending account." These accounts are completely separate and apart from the employer's main group health plan, and are designed primarily to cover deductibles, copayments, and other medical expenses not fully covered by the main plan (glasses, psychotherapy, orthodontia, etc.). Since the employee can keep the money in cash, there is no reason whatsoever to elect to make a contribution if the employee's money in the account will have to be applied to health expenses not paid by the main plan before those expenses can be submitted to Medicare.

Proposed Answer #1: Again, if it's permitted under Section 125 of the Code, it will not be subject to MSP. Therefore, health flexible spending accounts authorized under Section 125 of the Code will not be expected to be primary to Medicare.

Proposed Answer #2: Health flexible spending accounts that are exempt from HIPAA — those which provide maximum benefits no greater than twice the employee contribution or \$500 more than the employee contribution, and which are offered to individuals who are already offered covered by another true major medical plan of an employer — will not be subject to MSP.

Actual Answer: The regulation project they have been working on relates to several issues relating to the integration of 125 plans with the MSP rules. They prefer to hold comments until that is issued.

4. **Privacy Regulations.** The proposed privacy regulations place burdens on "plans" but not on their "business partners." Plans are required to contract with their business partners to make sure that the business partners follow the same restrictions to which the plans are subject.
- a. What is the consequence for a plan that is careful about contracting with its business partners, but nevertheless a business partner breaches the contract and improperly releases identifiable medical information (or the business partner otherwise violates the requirements of the regulations)?

Proposed Answer: No consequence, because the plan was prudent in exercising its responsibilities, even if its business partner let it down.

Actual Answer: They basically agree with the proposed answer, but the proposed rule requires a plan to take corrective action for breaches, and to terminate or non-renew a business partner with a pattern of non-compliance. If, however, the plan "knew or should have known" of the business partner's noncompliance or breach of this provision, the plan will be subject to enforcement action. They would want the plan's punishment of the business partner to fit the crime. If it was a weird systems glitch, fixing it might be enough. If it was a rogue employee, that employee would have to be disciplined or terminated. If it was a contracting entity that simply could not control its systems or employees, the plan might well be expected to terminate that contractual relationship.

- b. Indeed, in the case of an employer-sponsored ERISA plan that is funded solely by employer and employee contributions, who is penalized and in what manner if the plan fails to contract with its business partners in the required manner?

Proposed Answer: No penalties will be imposed against plan assets. Also, the employer is not penalized, since only the plan is subject to regulation under the privacy regulations.

Actual Answer: They don't agree with the proposed answer. The plan or covered entity is ultimately responsible. However, they haven't figured out how to make it work when the plan is just a piece of paper or the only plan assets are employee premium payments. The people who wrote the statutory provisions did not understand ERISA at all, and they are trying to figure out what to do about it. Administration legislative proposals are out there. To the extent that there is no legislation, they will do the best they can to take the real world of ERISA health plans into account.

They were hoping to get final regulations out in the summer of 2000, but it is more likely that they will get final regulations out by the end of 2000. If they have to change something big, like the consent requirements, it will require significant revision to their policy decisions.

[JCEB Note: Final rules were issued in 2000.]

5. Individual and Small Business Policies.

- a. Has there been any progress in limiting the excessive premiums that some insurers were charging HIPAA-eligible individuals, or in limiting the enrollment delays that can cause a 63-day break in coverage if the policy is not ultimately issued?

Answer: They aren't hearing of as nearly many violations as they were in the early years of the HIPAA mandates.

- b. One person who was trying to line up continuation coverage before the prior coverage ceased reported that an insurer told her specifically that it would not accept an application until 63 days after the end of the old coverage. Is this allowed?

Answer: This should not happen. However, they don't really have the statutory mandate to go in to enforce the law in individual situations. But people experiencing such violations should contact them, and if they get enough complaints, they will go into a State to see what is happening, and if they find the law is not being enforced, then they will take action.

- c. Which states have notified HCFA that they intend to rely on the federal default provisions and which states have developed their own alternative provisions?

Answer: They handed out two charts, "[Characteristics of Acceptable Alternative Mechanism Submissions](#)" and "[Federal Fallback States](#)," showing actions taken by various states.

- d. Which states will require federal enforcement of the default requirements, and which states will enforce those requirements themselves? Will HCFA have the resources to enforce the federal requirements in states that do not cooperate?

Answer: HCFA expects to have the resources to take whatever action is necessary and appropriate in line with their statutory mandates. See attached charts for status of various state actions.

- e. Is it possible that in a state whose legislature has adopted acceptable alternative provisions, that state's enforcement arm would fail to enforce those provisions? If so, would HCFA intervene as in any other non-compliant state?

Answer: This is a sensitive political issue, and they can only act based on complaints. If there are a lot of complaints, they may step in and take over enforcement. Individual complaints will be followed up and hopefully resolved by the states.

- f. Have many insurers withdrawn from the individual or small business market altogether (while still writing other health insurance) rather than comply with HIPAA's requirements?

Answer: They hear some complaining, but they have no statistical data on massive pullouts. The attached handout shows who initially applied for alternative mechanisms. A couple of States (Michigan and Massachusetts) took some time to adopt their programs. Massachusetts hasn't adopted it yet, but people seem to be getting coverage, so they are not overly concerned. California (individual market only) notified them, as did Missouri and Rhode Island, that it had not been adopted, so HCFA is enforcing federal guidelines in those three states.

Some State Alternative Mechanisms ("SAMs") are under study. Delaware decided not to. Colorado may come in with an alternative mechanism using a high risk pool. Several states used the 6 month extension to try to work out alternative mechanisms but ended up with the federal fallback rules.

6. **HIPAA Data Bank Reporting.** Under HCFA's recent regulations for group health plans to report settlements with providers, what scenarios do you see as calling for reporting? This is somewhat puzzling, because most group health plans don't do their own physician credentialing the way hospitals or network providers do, so the plan would rarely be aware that a physician had been dismissed from its network.

Answer: People necessary to answer this question were not able to be present at meeting.

7. **Identifiers.** Can you give us a progress report in HHS' efforts to select workable "unique health identifiers," particularly for individuals?

Answer: They are trying to get regulations out. Their current schedule calls for final rule for transactions and coding standards to be issued by June 30, 2000. That should be the keystone of the project. They hope the regulation will clarify the confusion as to who is responsible for what.

Providers, plans, employers, and individuals, will each have separate identifiers, with health plans being the easiest to assign. There is still controversy about provider and individual identifier numbers. Initially, they were going to issue a notice of intent to propose regulations, and there was so much objection that they didn't do even that. It was decided not to do any further work on that until the privacy regulations are in place. Rules for provider and employer numbers have been proposed, and final rules are expected by the end of the current calendar year. The proposal was to use the IRS Tax ID number for employers. Although there were a couple of objections, that was pretty non-controversial. For providers, they chose 8 digits with numbers and letters, but many commenters objected to mixing letters and numbers for keying in purposes and suggested using a 10-digit number with numbers only. Other commenters were concerned that too much information was being collected.

Once the standard is adopted, entities will have 2 years to get technology to comply. They want to make sure the system is built before they finalize the rules, and the entities can't create their systems until the government decides on the final rules.

Proposed rules on providers should be out by the end of the year. They will define what a provider is. An employer won't be a provider, even should it arrange for care to be provided to employees.

They are working on identifiers for plans and hope to propose a rule by the end of the year. They want to be able to use it as an electronic phone book, so that once you know the identifier number you know the address to which to send a claim.

HCFA is moving ahead with its own security plan, as it develops the rules. Other federal agencies won't be required to take any action until the rules are released. Once the rules are released, federal agencies will be as subject to them as anybody else.

Follow-up Question: We asked if there will be any funding to assist rural providers?

Answer: Not likely, but rules will attempt to be scalable, with the level of effort required being variable based on the circumstances of the provider. They haven't determined final compliance and enforcement rules. There likely will be a good faith requirement, so that in the case of an entity that has tried, they may give them some period, such as 90 days, to take any additional actions deemed to be required.

Every employer will have to request a number, and will need to be using the numbers by the end of the two year compliance period.

8. **MSP Data Match Program.** What is the status of this program? Are individual employers still being asked whether Medicare claimants have employer-sponsored coverage, and related questions (other than through the enforcement process when HCFA has actual information that a plan has paid as secondary when it should have paid as primary)?

Answer: The program is alive and well. The sunset was removed, so the program is now permanent. Questionnaires are now going out annually instead of every two years. They have gotten a lot of money out of this program -- \$350 million. There is an alternative mechanism for data match reporting currently, to phone 410-786-5787 or e-mail Hgamble@hcfa.gov. The reporting entities that use this alternative don't have to do annual questionnaires, and under this program HCFA will give information back about who is Medicare-eligible in addition to the plan giving information to HCFA. They are also seeking data sharing with insurers. Data Match Questionnaire 7 is going out right now, and that would have to be answered even if someone entered into the data sharing agreement now for future years, but if an entity now puts all the data for the past period into the new arrangement, then they don't have to duplicate that on a Data Match questionnaire. Spousal social security numbers will be required for those spouses for whom the employer can't provide a Medicare number.

The Data Match contractor, Group Health, Incorporated, a not for profit insurance company in New York City, is also doing COB coordination. That way, instead of pay and chase, they can put more resources into finding out in advance when there is another plan that should be primary.

9. **Self-Insured Plans with Stop-Loss Coverage.** Clearly, self-insured plans must comply with HIPAA, just as insured plans must do. In the case of an insured plan, however, the insurer is also specifically required to comply. The following questions were asked the last couple of years, but HCFA was not yet ready to answer them at those times. We'd appreciate any update that you can give us as to these questions:
 - a. In the case of a self-insured plan with stop-loss coverage, which is typically set up so that the employer funds whatever benefits the employee premiums don't cover, must the stop-loss insurers comply with HIPAA

(particularly the limitations on pre-existing condition periods and the non-discrimination requirements)?

Proposed Answer #1: Since they only reimburse the employer, and normally do not pay benefits to employees and dependents, they are not required to comply with HIPAA.

Proposed Answer #2: Since they are issuing coverage with respect to a plan they know is subject to HIPAA, they must structure their policies to match the employer's requirements. (This is what employers would prefer, because the alternative is that the employer is insuring the HIPAA-protected cases even at catastrophic levels. In many cases, the imposition of a pre-existing condition exclusion period — or even red-lining a risk altogether — by stop loss carriers could create an insolvency risk preventing the employer from being able to honor its HIPAA obligations to a person against whom discrimination is prohibited.)

- b. Instead of the employer purchasing stop-loss coverage to protect itself against catastrophic obligations under the plan, suppose a plan itself purchased a stop-loss policy with plan assets. Would the answer to 9.a. change?

Proposed Answer #1: No change. Since the stop-loss policy still only reimburses the party who promised the benefits, and does not contemplate the payment of benefits directly to employees and dependents, the insurer still is not required to comply with HIPAA.

Proposed Answer #2: Since the stop-loss policy has become a "plan asset" by virtue of its purchase with plan assets, it is a part of "the plan" for HIPAA purposes, and must not take actions inconsistent with HIPAA's requirements for other parts of "the plan."

Answer: They consider all of this to be a DOL issue, and understand that the DOL does not plan to act.

10. Medicare Secondary Payor.

- a. Must a plan covering other transplants cover kidney transplants? If the plan has a cap on coverage of transplants, can kidney transplants be similarly covered?
- b. What happens if there are different caps for different types of transplants — based, for example, on what the plan projects it would cost to pay for one transplant of that particular organ? One kidney transplant may cost less than, for example, a combined lung/pancreas transplant, so the cap for

lung/pancreas transplants might be a higher dollar cap than the cap on kidney transplants. Is this permissible?

Answer: No specific answer given.

11. **Fraud and Abuse.** Are HHS and HCFA making efforts to enforce HIPAA's new fraud and abuse provisions in the non-Medicare sector?

- a. Are enforcement efforts likely to be aimed primarily at doctors, hospitals and similar providers, at claimants, or at some other group(s)?
- b. Will organizers of fraudulent MEWAs or other fraudulent health insurance arrangements be targeted under this legislation, or will it be limited to providers and claimants?
- c. Will "erroneous" bills from health care providers ("accidentally" charging full price when a discount has been agreed to, for example) be deemed fraudulent under HIPAA if they are the result of a billing system not properly established and monitored, or will only willfully false bills be targeted?
- d. Will a provider's organized or intentional waiver of deductibles and copayments, without the consent of the plan or contrary to its terms, be deemed fraudulent? If so, will just the provider — or also the patient — be guilty of fraud? Will HCFA or HHS attempt to stop such practices, or will it be the responsibility of the plan itself to identify and stop them?

Answer: People necessary to answer these questions were not able to be present at meeting.

12. **Privacy Regulations.** If a plan benefit would not be offered at all (an aggressive wellness benefit, for example), except that the sponsor is willing to offer it if the results can be used to research its effectiveness, can enrollment in the program be conditioned on consent to the use of identifiable information for research purposes?

Answer: Great question, but something requiring a new specific consent isn't saved by virtue of its being voluntary, since all health benefits are voluntary.

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