

American Bar Association

**Technical Session Between the Centers for Medicare and Medicaid Services
and the Joint Committee on Employee Benefits**

May 5, 2008

The following notes are based upon the personal comments of the various individuals from the Centers for Medicare and Medicaid Services who attended a meeting with the representatives of the various sections comprising the Joint Committee on Employee Benefits from the American Bar Association. The comments were made by these individuals in their individual capacity and not as representatives of the Centers for Medicare and Medicaid Services. The comments do not represent the position of the Centers for Medicare and Medicaid Services or of any other government agency or office. None of the comments should be considered official guidance or the position of any agency.

This document has been prepared by private sector members of the American Bar Association's Joint Committee on Employee Benefits who were present at the meeting and reflects their description of the answers to the questions that were discussed at the meeting. This document has not been reviewed or cleared by the government individuals involved in the meeting.

Medicare Secondary Payor Issues

1. MSP Rules for HSAs.

Background: MMA, enacted in December of 2003, creates “Health Savings Accounts,” or “HSAs” under IRC Section 223. HSAs may be offered under a Code Section 125 cafeteria plan, but also may be offered separately outside of IRC Section 125. Although not typical, an employer may offer only the “High Deductible Health Plan,” or “HDHP,” and leave it up to the individual to arrange for his or her own HSA. Both employers and employees may contribute to HSAs, subject to the dollar limitations in IRC Section 223.

Question: Are HSAs exempt from the MSP rules?

Proposed Answer: Yes. The Part D Coordination of Benefits Guidance provides in Section V. E. 1. that health savings accounts are exempt from MSP. This applies for all MSP purposes, and not just Medicare Part D.

CMS Response: CMS officials declined to answer this question.

2. Medicare Secondary Payer and Health Savings Accounts.

Background: 42 CFR Section 411.102(b) provides that a group health plan of an employer with at least 20 employees may not take into account the age-based Medicare entitlement of an individual or spouse age 65 or older who is covered or who seeks to be covered under the employer’s health plan. In addition, 42 CFR Section 411.103 provides that an employer is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment, in a group health plan that is, or would be, primary to Medicare.

Employer sponsors a health plan that is a high deductible health plan within the meaning of IRC Section 223. Employer also makes contributions to the health savings account (HSA) of an employee who is enrolled in the high deductible health plan. However, if an employee is enrolled in Medicare, the employee and his or her employer are not eligible to make contributions to an HSA. See, IRC section 223(b)(7).

Question #1: If an employee enrolls in an employer’s high deductible health plan and the employee is also enrolled in Medicare, the employer is prohibited from making a contribution to an HSA of that individual. Even though the employer is prohibited from making an HSA contribution for Medicare enrollees, do the Medicare Secondary Payor rules require the employer to provide an equal payment to the Medicare enrollees outside of an HSA?

Proposed Answer #1: In this example, the Medicare enrollee is still enrolled in the high deductible health plan that is primary to Medicare. Even though the employer cannot

make an HSA contribution for a Medicare enrollee, the Medicare Secondary Payor rules do not require an equal payment outside of the HSA to a Medicare enrollee.

CMS Response: CMS officials declined to answer this question.

Question #2: Using the same facts as provided above, because a Medicare enrollee would not be eligible for an HSA contribution, the employer allows Medicare enrollees to waive participation in the high deductible health plan. At this point, because the Medicare enrollee is no longer participating in a group health plan, Medicare becomes the primary payor. If a Medicare enrollee waives participation in the high deductible health plan, the employer provides the Medicare enrollee with a make-up payment (that is treated as taxable cash compensation) so that the Medicare enrollee may purchase individual insurance. If an employer provides such a payment, will the payment violate the provisions of 42 CFR Sections 411.103 or 411.102?

Proposed Answer #2: Because a Medicare enrollee is not eligible to receive an HSA contribution, the Medicare enrollee may not wish to enroll in the high deductible health plan, which is structured to operate in conjunction with the HSA. Under 42 CFR 411.172(c), a Medicare enrollee may refuse to accept the health plan offered by the employer. If the employee refuses to enroll in the health plan, then Medicare is the primary payor. Therefore, the employer is not paying the Medicare enrollee to not enroll in the high deductible health plan. Rather, the employer is providing a make-up payment that is roughly equal to the value of the high deductible health plan coverage, if the Medicare enrollee chooses not to enroll. Therefore, the provisions of 42 CFR Sections 411.103 and 411.102 are not violated.

CMS Response: CMS officials declined to answer this question.

3. **MSP Rules for HRAs.**

Question: IRS Notice 2002-45 provides guidance regarding Health Reimbursement Arrangements or “HRAs.” These accounts will be entirely funded by employers, to reimburse employees and their dependents for medical expenses not otherwise covered by a regular group health plan. Because there is no opportunity for the individuals to receive the funds for anything other than qualifying medical expenses under Code Section 213(d), a cafeteria plan under IRC Section 125 is not needed in order to make the HRA reimbursements free from tax. Therefore, they fall outside the exemption articulated in your May 29, 2002 letter regarding IRC Section 125 cafeteria plans. However, administering these generally small accounts will be much more complicated if the accounts must be primary to Medicare for the employees receiving Medicare benefits (or those with family members receiving Medicare benefits). Is it CMS’ position that HRA accounts must be exhausted before Medicare is required to pay any amounts not otherwise covered by the regular group health plan covering the employee or family member?

Proposed Answer #1: No, payments made to employees or their family members pursuant to an HRA that complies with the requirements of IRS Notice 2002-45 will not be required to be primary to Medicare.

Proposed Answer #2: HRA accounts that 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 coverage by another regular major medical plan of an employer will be exempt from MSP. (Based upon the exemption from HIPAA for health FSAs. See, Treas. Reg. 54.9831-1(c)(3)(v).)

CMS Response: CMS officials declined to answer this question.

4. San Francisco Health Care Security Ordinance and MSP.

Background: The San Francisco Health Care Security Ordinance generally requires that an employer with 100 or more employees make “health care expenditures” on behalf of each “covered employee” equal to \$1.76 per hour paid to the covered employee. See S.F., Cal. Admin. Code Chap. 14, §§14.1 – 14.8 (2007) (“HCSO”).

“Health care expenditures” include:

- Contributions by an employer on behalf of its covered employees to a health savings account as defined under IRC Section 223 or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income;
- Reimbursement by an employer to its covered employees for expenses incurred in the purchase of health care services;
- Payments by an employer to a third party for the purpose of providing health care services for covered employees;
- Costs incurred by an employer in the direct delivery of health care services to its covered employees; and
- Payments by an employer to the City of San Francisco to be used on behalf of covered employees. HCSO §14.1(b)(7).

A “covered employee” is, generally, an employee who has worked at least 10 hours per week in San Francisco for at least 90 days. However, a “covered employee” does not include:

- Certain managerial employees who earn at least \$72,450.00 in 2007 (as indexed);
- Persons who are eligible to receive benefits under Medicare or TRICARE/CHAMPUS; and

- Persons receiving health care services through another employer (either as an employee or by virtue of being the spouse, domestic partner, or child of another person), provided that the employer obtains from those persons a voluntary written waiver of the health care expenditure requirements and such waiver is revocable by those persons at any time. HCSO §14.1(b)(2).

If an employer fulfills the requirement to make health care expenditures by making contributions to the City, the City will use the employer's contributions to provide one of two programs to the covered employees on whose behalf contributions were made:

- **Healthy San Francisco:** The City will offer the Healthy San Francisco program to covered employees who meet specified eligibility requirements. An employee enrolled in the Healthy San Francisco program will be able to get basic medical care through a limited network of health care providers.
- **Medical Reimbursement Accounts:** The City will offer medical reimbursement accounts to covered employees who do not meet the eligibility requirements for Healthy San Francisco. The City will be responsible for the medical reimbursement accounts; the employer will not sponsor or control an employee's medical reimbursement account. An employee will be able to use the funds in his or her medical reimbursement account to pay for out-of-pocket medical, dental, and vision care expenses. HCSO §14.2 and <http://www.healthysanfrancisco.org/employers/> (as visited 3/12/2008).

Question 1: Assume that an employer fulfills the requirement under the HCSO to make health care expenditures by making contributions to health reimbursement accounts for each of its covered employees. However, the employer does not make comparable health care expenditures for its employees who would have been covered employees but for their entitlement to Medicare. (See above where a person entitled to Medicare is not included as an employee covered by the HCSO.) The health reimbursement accounts are an employer-sponsored plan subject to ERISA. Would the contributions be a violation of the Medicare Secondary Payer rules?

Proposed Answer 1: The fact pattern described in Question 1 would be a violation of the Medicare Secondary Payer rules. Because the health reimbursement accounts are an employer-sponsored group health plan, the failure to make contributions on behalf of employees entitled to Medicare would violate 42 CFR §411.102(b) and (c).

CMS Response: CMS officials declined to answer this question.

Question 2: Assume that an employer fulfills the requirement under the HCSO to make health care expenditures by making contributions to the City. However, as allowed by the HCSO, the employer does not make comparable health care expenditures on behalf of its employees who would have been covered employees but for their entitlement to

Medicare. Would the contributions be a violation of the Medicare Secondary Payer rules?

Proposed Answer 2: For purposes of the Medicare Secondary Payer rules, “the term ‘group health plan’ has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.” 42 USC §1395y(b)(1)(A)(v). IRC §5000(b)(1) defines a “group health plan” as:

...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.

“Group health plan” is further defined in 42 CFR §411.101 as:

...any arrangement made by one or more employers or employee organizations to provide health care directly or through other methods such as insurance or reimbursement, to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that--

- (1) Is of, or contributed to by, one or more employers or employee organizations.
- (2) If it involves more than one employer or employee organization, provides for common administration.
- (3) Provides substantially the same benefits or the same benefit options to all those enrolled under the arrangement.

There is a dispute among practitioners whether contributions to the City for medical reimbursement accounts are “group health plans” within the definition in IRC §5000(b)(1) and 42 CFR §411.101. Some practitioners believe that the City health programs under the HCSO are group health plans for MSP purposes. This is because the City health programs are contributed to by the employer on behalf of the employer’s employees. Other practitioners believe that the City medical reimbursement accounts are not group health plans for MSP purposes. This is because while an employer contributes to the “program” for its employees, the “program” in question is operated and sponsored by the City for a number of individuals, most of whom are not the employer’s employees.

CMS Response: CMS officials declined to answer this question.

Question 3: Assume that an employer fulfills the requirement under the HCSO to make health care expenditures by making contributions to an HSA on behalf of each of its covered employees. However, the employer does not make comparable health care expenditures on behalf of its employees who would have been covered employees but for

their entitlement to Medicare. Would the contributions be a violation of the Medicare Secondary Payer rules?

Proposed Answer 3: The fact pattern described in Question 3 would not be a violation of the Medicare Secondary Payer rules. As provided in these Questions and Answers, an HSA is not subject to the MSP rules.

CMS Response: CMS officials declined to answer this question.

5. **MSP Reporting.**

Background: Section 111 of Public Law 110-173 imposes new reporting requirements on group health plans. These reporting requirements are effective January 1, 2009. Many of the reporting requirements are left to be implemented by CMS.

Question 1: When do you anticipate issuing guidance regarding the reporting requirements?

Question 2: What do you anticipate the frequency of the reporting to be?

Question 3: For self-insured plans, the law requires the “plan administrator” or “fiduciary” to provide the information, and imposes a fine if the information is not so provided. Many self-insured plans have split fiduciaries, with a third party administrator being the fiduciary for claims and the employer (or benefits committee) being the fiduciary for other purposes, such as eligibility determinations. Do you anticipate imposing the filing requirements on the fiduciaries who are the third party administrators because they are the ones with the information that will need to be reported, or do you anticipate imposing the filing requirements on the plan administrator (which is the employer in most cases)?

Question 4: Do you anticipate the penalty being discretionary or mandatory?

Question 5: Will each plan be required to enter into a Voluntary Data Sharing Agreement (VDSA) in order to comply with the law? If not, please explain the role of VDSAs in light of the new reporting requirements.

CMS Response: CMS will not be proposing regulations, but rather will be doing a Paperwork Reduction Act notice in the Federal Register. Guidance regarding the new mandatory reporting will then be posted to <http://www.cms.hhs.gov/MandatoryInsRep> after the paperwork reduction act notices are published in the Federal Register. CMS expects that guidance should be posted to the site sometime in July.

Because the guidance is not completed, CMS could only discuss the framework of the guidance and certain general terms and conditions. General comments regarding the guidance is as follows –

- The new requirement will not change the existing reporting structure. CMS will still be doing voluntary data sharing agreements (VDSAs) and data match forms and questionnaires.
- CMS expects that VDSAs with employers/insurers will at some point be converted into the mandatory reporting, but that at least for now, these will be separate reporting regimes.
- The guidance will clarify who has the legal reporting obligation under the new law, and this entity may or may not be the entity that will ultimately be performing the reporting.
- The data elements that will be a part of the mandatory reporting will be those elements that are needed for COB activities.
- Before the effective date of the new law, group health plans will need to complete a registration package and after submission of the package CMS will tell them the reporting dates for the health plan. These dates will be on a quarterly basis and will be unique to each group health plan, because CMS will need to manage the data flow. In other words, not every group health plan will be reporting on the same dates.
- CMS will be considering a web-based direct data entry for small groups, such as less than 10 individuals per quarter.

HIPAA Security

6. Remote Use of Electronic Media.

Question: In December 2006, CMS issued guidance regarding procedures that could be followed with respect to the remote use of electronic media, such as laptops, and what covered entities could do when a laptop is stolen or otherwise misplaced. In 2007, CMS discussed incorporating this guidance into an actual amendment to the HIPAA security regulations. Does CMS anticipate issuing any amendments to the HIPAA security regulations regarding the remote use of electronic media or remote access to E-PHI?

CMS Response: Encryption of laptops is an addressable implementation, and not an absolute requirement. However, addressable does not mean optional. Covered entities must examine laptop encryption and if a covered entity decides not to adopt encryption standards, it must implement a suitable alternative and must document in its policies and procedures the reasons for the alternative.

An employer group health plan would be ultimately responsible for a third party administrator / business associate data breach. Therefore, group health plans should perform due diligence on TPA policies and procedures for laptop encryption and other security measures. Group health plans should also assure that contracts require TPAs to protect data. The privacy regulations specifically say that there is no duty to monitor, but the ERISA prudence rule may require some level of monitoring in this area.

There are no plans at this time to amend the HIPAA Security Regulations to include the remote use guidance.

7. **HIPAA Security Audits.**

Background: Recently, CMS announced that it has started a limited audit program to audit covered entities for compliance with the HIPAA security regulations. These audits will be based on complaints received by CMS.

Question #1: Can CMS provide any information regarding whether any group health plans were selected for audit?

Question #2: Can CMS provide any information regarding any major violations that were discovered?

CMS Response: CMS does not disclose specific details regarding audit activities. However, the penalties will, in part, depend upon the level of cooperation, and civil monetary penalties are not the goal, but are always possible in any audit case.

One of the major issues that CMS has seen is that covered entities are not updating their policies and procedures for changes in the security environment and the technological landscape. New threats to security have emerged and new technology has also emerged to combat those threats. Covered entities must periodically review and update their policies and procedures and update the security measures that are needed to protect PHI. Also, since the security rules were initially effective, there is more remote use of PHI with employees working at home and at other locations outside the office. Covered entities must also review and update their policies and procedures to account for remote use of PHI.

Part D

8. **Retiree Drug Subsidy Audits.**

Background: The MMA requires that plan sponsors or their plan administrator maintain records with respect to the Medicare Part D Retiree Drug Subsidy, and to make them available for audit in accordance with 45 CFR § 423.884(f) and 423.888(d).

Question #1: How often will each plan sponsor be audited under the RDS program?

Proposed Answer #1: Commercial PDPs and Medicare Advantage plans are audited each three (3) years, and for the RDS, each plan sponsor will be audited each three (3) years.

CMS Response: CMS has discretion as to when to audit, and there is no established audit cycle currently. Specifically, the every three year audit requirement does not apply to RDS in the question above.

Question #2: How many audits of RDS plan sponsors have been conducted, and with what results?

CMS Response: CMS and OIG (Office of the Inspector General) can perform their own audits independently. CMS works with OIG and provides feedback to OIG on its audit process, but ultimately OIG makes its own decisions with respect to audits. OIG has completed one audit, and this audit is listed on the CMS website. CMS intends to do its own audits in the future, but currently it has not established an audit process.

Question #3: Are there any plans to provide compliance assistance to plans by issuing audit checklists or other types of tools for plans to audit themselves?

CMS Response: CMS does not intend to issue any checklists per se. However, CMS does have certain “how to” documents posted on its website. In the future, CMS intends to consolidate some of the guidance listed on its website, once the RDS process begins to function more smoothly.

Question #4: Has OIG retained an outside company to audit plan sponsors or will it conduct the audits with internal staff?

CMS Response: Although OIG sometimes asks for CMS feedback, OIG conducts its own audits independently of CMS, and therefore CMS has no information to form a response.

Question #5: Is there a list of documents that will be requested in a plan sponsor RDS audit? If so, have you released this list or do you intend to do so?

CMS Response: See Regulation Section 423.888(d), which discusses maintenance of records. In general, the type of information that would be requested include enrollment, eligibility and claims data.

Question #6: Is there a list of discussion topics that will be raised at an RDS audit? If so, have you released this list or do you intend to do so?

CMS Response: There is no formal list. It would depend on the specific facts of the situation and how forthcoming the employer was when documentation was requested. If documentation is incomplete or non-existent, then this will lead to additional issues and requests for information in the audit.

Question #7: How many audits of RDS plan sponsors have been conducted, and with what results?

CMS Response: CMS has not yet conducted its own audits, but intends to do so in the near future.

Question #8: How will OIG approach correcting violations that it finds on audit? Will prospective correction approaches be used, or will RDS subsidies be affected?

CMS Response: CMS cannot discuss the OIG perspective, but CMS can discuss its own perspective, assuming CMS conducted the audit. If there is fraud or mis-representation that is uncovered in the audit, then that is a serious problem that will need to be handled. There are no civil monetary penalties that specifically relate to RDS, but CMS can freeze future RDS payments or cancel an employer's participation in the RDS program. Absent fraud or mis-representation, CMS will work with the sponsor to correct issues and non-compliance. While CMS verifies that the corrections were implemented, CMS can freeze future RDS payments.

9. **Retiree Drug Subsidy Applications.**

Background: In 2008, plan sponsors began receiving emails that included a denial of the RDS application.

Question #1: Please explain the new automated denial process.

Question #2: Please explain the process for filing an appeal (or any kind of reconsideration), including the procedural requirements and how the levels of appeals work.

Question #3: Please explain who reviews appeals and the criteria used for deciding them.

CMS Response: RDS applications are received on-line. If CMS does not receive all the materials (such as the application and retiree list) by the deadline, then the application is automatically denied. Employers can log onto the RDS center website and request an appeal of this denial. This can be done on the website, or the employer can submit a written appeal, but electronic appeals are encouraged.

The appeal procedures are located in Regulation Section 423.890. There is a 3-step appeal process. The first step is an informal reconsideration, which can be done on-line as discussed above. The second step is a CMS informal hearing, and the third step is a CMS administrator review.

At the informal reconsideration phase, employers can submit new evidence and provide their reasons for not meeting the applicable deadlines. This is a facts and circumstances test, but CMS flexibility regarding waiving of deadlines is waning because the guidance has become clearer. No new evidence can be submitted at the 2nd and 3rd levels of appeal.

A sponsor can also request that an application be re-opened under Regulation Section 423.890(d), if the request is done within certain time frames.