AMERICAN BAR ASSOCIATION

JOINT COMMITTEE ON

EMPLOYEE BENEFITS

HEALTH CARE FINANCING ADMINISTRATION

QUESTIONS AND ANSWERS

MAY 9, 1994
HCFA Questions and Answers for JCEB Session

1. Suppose an employee becomes ill, and is continued as a paid employee on extended leave beyond the period that he is approved for disability benefits by SSA and becomes covered by Medicare. Alternatively, suppose the employee is using a large amount of accumulated sick leave and/or vacation pay. Under HCFA’s new policy following the OBRA 1993 amendments, is Medicare primary for such an individual at the point he becomes covered by Medicare as a result of his disability, or could the Medicare-primary date be delayed depending upon the type of compensation he is receiving from the employer?

   ANSWER: The focus should be on whether the individual is providing current services for the employer (although being on a vacation for some period of time might be consistent with current services).

   a. Is the answer any different depending on whether the employer has registered the employee with HCFA as being disabled?

      ANSWER: Not specifically answered.

   b. At the point at which Medicare becomes primary (or the employer reasonably believes that Medicare is primary), is there any problem with the employer paying the disabled employee’s Part B premium or providing other inducements for the employee to enroll in Medicare?

      ANSWER: No problem with paying Part B premium once employee is no longer MSP-protected.

2. Is HCFA’s recent announcement, dropping its former view -- that ESRD Medicare beneficiaries are entitled to their full periods of COBRA coverage despite entitlement to Medicare -- permanent? Or is that position still under study for assertion in future litigation?

   ANSWER: The position is permanent.

   a. Is the answer the same regarding disabled divorced spouses of participants who are still active employees, who would be entitled to 36 months of COBRA coverage in the absence of Medicare entitlement?

      ANSWER: They do not necessarily believe that the disabled divorced spouses are in the same position as ESRD people, because COBRA entitlement, even to a disabled family member, is not based on anybody’s current employment status. In ESRD, however, the MSP entitlement is not based on current employment.
b. What is HCFA's reaction to the statement of the court in the Blue Cross/Blue Shield of Texas case that the MSP rules are only designed "to provide for the order of payments of benefits when dual coverage exists under Medicare and some other insurance....Nothing in the MSP Statute itself, or its legislative history, suggests that it was designed to extend coverage or require coverage that does not exist." This statement would seem to indicate that, in essence, the MSP rules are nothing more than coordination of benefits ("COB") rules, and that the way an employer could get around them is to just deny coverage to Medicare-eligible people. If this is true for COBRA beneficiaries in MSP-protected categories (such as ESRD and disabled ex-spouses of active employees), what is the difference between COBRA beneficiaries and other participants? In other words, if an employer can avoid having its plan be primary for a COBRA beneficiary by simply excluding the COBRA beneficiary from coverage upon Medicare entitlement, why (other than general age discrimination rules) cannot an employer simply exclude other Medicare-eligible employees or dependents from the plan?

**ANSWER:** They don't agree with the COB-only rationale of the case. However, COBRA is a federal statute, which does say on its face that it is permissible to terminate on Medicare entitlement, and makes no distinction as to the reason for Medicare entitlement. Employer plans who attempted to exclude people on account of Medicare entitlement would be viewed by them as on an entirely different footing, and it is their position that that would be discrimination in the provision of benefits against people entitled to Medicare.

3. COBRA clearly permits COBRA beneficiaries who become entitled to Medicare after making a COBRA election to be excluded from COBRA upon Medicare entitlement. The language is somewhat ambiguous as to whether beneficiaries who are already enrolled in Medicare at the time of their qualifying events can be similarly excluded from COBRA. The announced IRS position has been that people who are already enrolled in Medicare at the time of their qualifying events do not have to be offered COBRA. However, a recent COBRA case took the opposite view, and held that only people who enrolled in Medicare after making a COBRA election could be excluded from COBRA, and those already enrolled at the time of the COBRA election could stay under COBRA. If a plan follows that case, and allows a person enrolled in Medicare to elect 18 months of COBRA coverage upon termination of employment, would Medicare be primary for that person?

**ANSWER:** Yes. Medicare is primary for non-MSP protected individuals who happen to be on both Medicare and
covered by a plan. Since COBRA people other than ESRD beneficiaries are not considered MSP-protected, Medicare will be primary for those individuals.

a. Certainly, as a terminated employee, the person is no longer in an MSP-protected category. However, COBRA has a general rule that COBRA beneficiaries are entitled to all the benefits and privileges available to active employees. Therefore, some COBRA analysts have suggested that, if the plan was primary for a COBRA participant before his COBRA election, the beneficiary continues to be entitled to the same order of coverage after his COBRA election. Others, however, contend that all COB rules, including the MSP order of benefit payment rules, are outside the scope of COBRA, since it does not matter to the individual which plan pays his benefits. Does HCFA have a position as to whether anything in COBRA overrides the normal MSP order of payment rules for non-actives who do not have ESRD?

ANSWER: HCFA claims no specific COBRA expertise. However, their position under the MSP rules is that Medicare would be primary for non-ESRD people on COBRA.

b. If Medicare would be primary for an employee who is about to terminate employment and be covered by COBRA, and who could also enroll in Medicare, would HCFA have a problem with the plan sponsor paying the employee's Part B premium or otherwise inducing him to enroll in Medicare?

ANSWER: No problem for non-ESRD COBRA beneficiaries.

4. HCFA has announced that a plan that excludes coverage for all organ transplants need not cover kidney transplants. Does that mean that a plan covering organ transplants only up to a transplant-specific lifetime cap may similarly limit the coverage for kidney transplants?

ANSWER: In general, yes.

a. What if the plan has different caps for different types of transplants? Must kidney transplants be covered up to the highest cap applicable for the highest-paid organ transplant?

ANSWER: Kidney transplants must be subject to the highest cap available for any organ transplant. It is also conceivable that separate kidney transplant caps might be permissible if they can be actuarially demonstrated as appropriate to fully cover the kidney transplant.
b. Are there any circumstances under which an employer-sponsored plan covering most medical conditions can similarly refuse to cover (or cap the coverage of) kidney dialysis?

ANSWER: If a plan excludes dialysis for all covered persons and for all conditions, whether acute or chronic and regardless of the severity of the need, then the same exclusion can be applied to people with ESRD. However, if dialysis would be covered for people with acute short-term needs, it must also be covered for people with ESRD.

5. HCFA's regulations permit a rehired retiree who has health coverage as a retiree to return to work yet continue to be covered by the retiree plan, with Medicare being primary, so long as he does not meet the coverage requirements for the active employee plan. Suppose retiree coverage is added to an insured plan but only the aging CEO is eligible for such coverage. Then suppose the employer, who previously had taken the position that the CEO was full time in order to have him covered by the plan when it only covered active employees, now takes the position that the CEO is only working part time, and treats him as a retiree and continues to cover him under the retiree feature of the plan. Would HCFA scrutinize such a situation?

ANSWER: When they investigate cases, they customarily require certifications of facts under penalties of perjury. They might be suspicious of the CEO situation, but in general, what people are willing to certify under penalties of perjury, they will accept that unless they have a reason to doubt it.

a. Would the CEO's entitlement to be treated as a returning retiree depend on whether he at least went through the motions of retiring and returning? If so, how long a "retirement" would be required before he could return without challenge from HCFA?

ANSWER: Whether he has "retired" is not really relevant. The question is whether he is receiving coverage as a result of current employment status, or whether he has ceased to qualify for the active employee coverage for based on the normal factors applied to active employee.

b. If his switch from full time to part time status is sufficient to justify the retiree coverage, does it matter whether the number of hours he works per week (or per year) actually changes? If so, would HCFA look just at his office hours, or would HCFA consider whether he is likely to be putting in "judgment" time even when he is not in the office.
6. Suppose an employer permits retiree coverage under its regular health benefit plan for individuals who have reached a certain age and completed a specified number of years of service. Therefore, an individual who has met those requirements will be covered under the plan whether or not he is working. Does the question of whether Medicare is primary or secondary depend on whether he is actually working the number of hours per week required for younger actives to be covered? Or can someone who has met the retiree age and service requirements be treated as a retiree (since entitlement to coverage does not depend on his working) even if he is still fully active and has not retired?

   ANSWER: In general, it depends on whether the person would be eligible for coverage based on the actual level of his current employment. If he is working the number of hours for which other people get coverage, then his coverage is based on current employment status. If he is working below that level, then he would not be covered as a result of current employment status.

7. ERISA § 101(f), Social Security Act § 1144 and 42 U.S.C. § 1320b-14 require employers (and, under certain circumstances, group health plans) to furnish data to the Health Care Financing Administration for establishment and maintenance of a Medicare and Medicaid Coverage Data Bank. This reporting requirement is effective beginning with the 1994 calendar year, and the first filing will be due February 28, 1995, with respect to the 1994 calendar year.

   a. The format required for the reporting of this information is not specified in the statute. Will a specific format be required?

   ANSWER: Data elements include name and TIN of covered individual, single or family coverage, type of coverage elected by each electing individual, including plan name and number, and name and address of entity that processes claims. Also name and TIN of all other covered individuals. Employer is not obligated to report on infants under 1 year of age, or on those prohibited from having an ID number. Also, name and tax ID number of the employer must be reported. The employer must make reasonable good faith effort to obtain information. Employer might not have names and SSNs for other covered individuals, but they should make a documented initial effort and a documented follow-up effort for people who do not respond to the first inquiry.
b. Will any specific forms be provided for reporting?

ANSWER: Yes. The form probably will be HCFA 163, not H-2. It will not be combined with the W-2.

c. What will be the annual deadlines for reporting (including the first year of reporting)?

ANSWER: They are seeking an 18-month postponement of the effective date of the statute. If nothing is done by Congress, they will expect compliance as specified in the statute and their recent press release. If no postponement is granted, they consider the law to be self-enacted, and needs no regulations for full applicability. Therefore, if there is no change they will expect compliance regardless of the issuance of regulations. If no Congressional delay, however, there will be further information released by the end of the summer, including a copy of the form, but they are not going to release those yet.

d. What will be the penalties for noncompliance?

ANSWER: $50 per report, up to a maximum liability of $250,000 per employer, with each separate employer ID number being viewed as a separate employer.

e. Will plans which are normally exempt from ERISA's reporting and disclosure provisions (e.g., church plans) also be exempt from any reporting which may be required under these new requirements which are contained under the non-ERISA Internal Revenue Code provisions?

ANSWER: All employers must report on all covered individuals, not just employees. Thus, retirees, COBRA participants, people on leave, independent contractors, etc., must all be subject of reports. Exact dates of coverage must all be reported, even if there are multiple coverage periods within a year.

Church plans are not exempt. In the case of nuns who are members of an order, who are not working for the order that supports them, but work for other employers, they are not sure who is required to report. IT MAY DEPEND ON WHETHER THE ORDER RUNS A HOSPITAL or a school through its own nuns, in which case the order would more likely be the employer of record. In a cloistered situation, it may be differ-
ent. Also, if the order has non-order employees in the plan, it is more likely to be the employer responsible for reporting. They noted that the Data Bank mandate is much broader than the MSP rules, in that all employers are required to report, whether they are subject to MSP or not.

Employer includes self-employed, so presumably the reporting requirement would include a plan covering only self-employed individuals. Does that include a plan covering only a single self-employed individual? They aren't sure if that is a group health plan. However, many self-employed people buy coverage through a large multiple employer plan, which clearly would be covered by the reporting requirements.

f. When does HCFA expect to issue guidance on this matter?

ANSWER: By August unless Congress postpones the effective date or gives a clear indication that postponement is going to happen.

8. Apparently, a multi-employer medical plan recently received a notice from HCFA, informing the plan that it was required to reimburse HCFA for medical expenses for which the plan should have been primary. The Medicare payment occurred approximately 10 years ago.

a. Which statute of limitations applies in this situation?

ANSWER: 6 years from when they had notice that they had a cause of action.

b. When does the statute of limitations begin to run? Presumably, it begins when HCFA has notice or can reasonably be expected to have knowledge that other coverage should be primary. If reimbursements may be requested many years after a Medicare payment is made, substantial time and expenses will be incurred in maintaining and reconstructing records and in seeking reimbursements from various employers. If the statute of limitations does not begin to run at some clearly ascertainable date, employers will never have any security that long-term claims may not resurface. Such uncertainty will require significant additional due diligence in connection with acquisitions, and indemnifications will have to remain outstanding potentially forever in a merger and acquisition context. Is it reasonable to assume that notice to HCFA of the possibility of another primary payor exists when a payment is made? If not, is there another fixed
date at which plans can be certain that the limitations period is running?

ANSWER: No, the statute does not begin to run when Medicare makes initial payment unless it is informed at that time that there is another plan. It only begins to run when they knew or should have known (based on actual information HCFA has received) that Medicare has a claim for reimbursement.
Supplemental HCFA Questions and Answers for JCEB Session

1. Can an employer sponsoring a large group health plan take the position that its plan is secondary to Medicare for certain disabled individuals who do not have current employment status with the employer without making any submission to or otherwise notifying its Medicare carrier?

ANSWER: Not directly answered.

2. Suppose an employer sponsoring a large group health plan takes the position that its plan is secondary to Medicare for certain disabled individuals who do not have current employment status with the employer. It submits information regarding these disabled individuals to the appropriate Medicare carrier to enable Medicare to change its records to reflect Medicare's status as primary payer. The employer is able to provide all of the information requested in HCFA's guidelines except for HIC numbers and the availability of coverage under a family member's health plan. The employer provides information for disabled individuals already covered by Medicare and for disabled individuals who have not yet satisfied the waiting period requirement to become entitled to Medicare benefits.

   a. Will the Medicare carrier process this submission for all disabled individuals, including those for whom information was omitted and individuals for whom the Medicare waiting period has not expired?

   ANSWER: No.

   b. How would the Medicare carrier respond if a disabled individual were covered under a family member's large group health plan where the family member had current employment status? In particular, would Medicare take the position that is it primary to the submitting employer's plan, but secondary to the family member's plan?

   ANSWER: Not directly answered, but NAIC COB guidelines call for the family member's plan to be primary, Medicare to be secondary and the employer's plan to be tertiary.

   c. If the Medicare carrier does not change its records with regard to individuals who have not yet completed the employer's waiting period for plan participation at the time of the notification, will the employer be required to resubmit information when each individual's respective waiting period expires? How will Medicare treat individuals who become disabled in the future?

   ANSWER: Not directly answered.

   d. If the Medicare carrier determines that it is secondary with regard to a particular individual and the employer
disagrees with that determination, how can the employer appeal the carrier's decision?

ANSWER: There is no specific appeal period. They are considering putting in an appeal procedure for plans that are deemed to be non-complying plans.

e. Does HCFA intend to issue regulations regarding Medicare's primary status for disabled individuals? If so, when will they be issued?

ANSWER: Not directly answered.

3. The Department of Labor is directed to consult with the Department of Health and Human Services before issuing guidance on qualified medical child support orders ("QMCsOs").

a. Is that the extent of the Health Care Financing Administration's involvement in the development of guidelines regarding QMCsOs?

b. When does HCFA expect guidelines on these orders to be available?

ANSWER: All questions on QMCsOs should be referred to the Department of Labor.

4. The Omnibus Budget Reconciliation Act of 1993 requires states to adopt certain changes to their laws to qualify for federal Medicaid funds. These changes include laws that prohibit a parent's plan from excluding dependent children who are born out of wedlock, are not claimed as dependents under the parent's federal income tax return, or reside outside of the parent's home, or the plan's service area. Will these laws apply only with respect to individuals eligible for Medicaid benefits?

ANSWER: All questions on QMCsOs should be referred to the Department of Labor.

5. An employer maintains a group health plan with an HMO option and an indemnity option. Employee A has opted out of coverage under the group health plan. Employee B has elected coverage under the HMO option. Employee C has elected coverage under the indemnity option. The group health plan receives identical medical child support orders with regard to the children of all of the employees. All of the orders require coverage for alternate recipients under the indemnity option. The employee determines that the order for Employee C satisfies the requirements for a QMCsO.

a. Would the employer's health plan have to provide coverage to the children of Employee A? Under which plan?
b. Would the employer's health plan have to provide coverage to the dependent children of Employee B? If so, would the employer have to provide coverage under the indemnity plan? If so, how should the employer calculate the employee's (or other parent's) contribution for this coverage?

ANSWER: All questions on QMCSOs should be referred to the Department of Labor.

6. A number of employers have received demand letters from Medicare carriers, seeking reimbursement in circumstances where Medicare has determined that it incorrectly paid primary benefits. Is HCFA treating insured and self-insured plans differently in its collection efforts? If so, how?

ANSWER: Insured and self-insured employers are not being treated differently. The employer, the insurer and the TPA are all considered jointly and severally liable for reimbursement to HCFA. In the case of an insured plan, they still feel it appropriate to go to the employer (who is the only party subject to the penalty tax under Section 5000 of the Code), and get reimbursement from the employer. The employer can then go to the insurer for redress (or better yet, put pressure on the insurer to cooperate with HCFA so that the employer will not have to pay and sue).

7. Are health flexible spending accounts established pursuant to Section 125 of the Code subject to the MSP rules?

ANSWER: Yes.

a. Is an employer required to provide information to the Medicare and Medicaid Coverage Data Bank with respect to employees who participate in a health flexible spending account?

ANSWER: Yes.

b. What about Employee Assistance Programs?

ANSWER: If they meet the definition of a group health plan, yes. Otherwise no.

8. If an employer shifts the responsibility to collect and provide the data to the Data Bank to a third party administrator, as permitted by Section 101(f) of ERISA, will the third party administrator be liable for the penalties for failing to report or will the employer remain liable for the penalties?
ANSWER: If the agreed provider of information is an "information maintainer," which would include insurers and TPAs, then only the information maintainer will be deemed responsible, and they will not look to the employer, so long as the information maintainer's failure did not result from the failure of the employer to accurately provide necessary information to the information maintainer.