

ABA Joint Committee on Employee Benefits
GOVERNMENT AGENCIES MEETINGS

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**ABA Sections of Business Law, Health Law, Labor
and Employment Law, Real Property, Probate and
Trust Law, Taxation and Tort and Insurance
Practice**

HCFA Questions and Answers

1. 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.

a. 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?

Answer: They now believe that people should not be penalized for participating in a cafeteria plan that qualifies under Section 125. That is an informal position now, but they hope to propose regulations someday.

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

Answer: Having to demonstrate other coverage creates some theoretical problems, but in general they would probably try to allow it if it's permissible under 125.

c. What if it's advice of non-taxable benefits not covered by Section 125?

Answer: If it's a choice of non-taxable benefits, they are not so sure it would be okay, since Congress took the phrase "unless provided to everybody" out of the statute. But the fact that 125 is only a constructive receipt avoidance mechanism is a factor that might make them allow it. Also needing consideration is the fact that denying a choice to the Medicare population would itself be both a violation of both the ADEA and MSP rules.

2. 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.

For purposes of COBRA, the Internal Revenue Service has specifically defined health flexible spending accounts to be "group health plans" under Section 5000 of the Code, and thus subject to COBRA. Since the definition for plans subject to the Medicare Secondary Payor rules is exactly the same Code provision, does HCFA consider health flexible spending accounts to be "group health plans" that would have to pay primary to Medicare?

Answer: By allowing everything permissible under Section 125, they are intending to include health flexible spending accounts as well, because it is something that was never designed to be a primary plan.

3. Regarding the states' responsibilities and options for meeting individual health insurance coverage requirements under HIPAA, please identify which states have notified HCFA that they intend to rely on the federal default provisions (which would trigger federal enforcement of the default requirements) and which states have developed their own alternative provisions.

Background: States regulate the individual health insurance market. Federal preemption of such state laws only applies if the state's standards undermined the minimum coverage provided by federal law.

On January 13, 1997, HCFA published a notice in the Federal Register setting forth the states' responsibilities and options for meeting individual health insurance coverage requirements under HIPAA. In the notice, HCFA asked states to provide notice by February 14 of their intention to either implement federal requirements or establish an alternative mechanism for satisfying the HIPAA requirements. HCFA also asked states which plan to develop their own alternative to the federal requirements to send an outline of the state program to HCFA by April 1, 1997.

Answer: They commented that the question seems to say that states relying on the federal default provisions would trigger federal enforcement. That is not true. The states may enforce the federal provisions, and HCFA will only intervene if they fail to do anything.

HCFA has received proposed alternative mechanisms from 40 states, most of them closely following the federal default provisions. They are checking with the rest of the states to determine their intent. A state that will use the federal scheme does not need to notify HCFA, so they aren't sure whether those not notifying them yet are just planning to go with the federal scheme.

4. Is HCFA developing a national coordination of benefits (COB) standard for ERISA group health plans under HIPAA?

Background: Although HIPAA does not explicitly require HCFA to develop a national COB standard for ERISA group health plans, the congressional intent in the Conference Report which accompanied HIPAA appears to require HCFA to develop such a standard. A national COB standard would preempt state COB laws governing insured health plans where an individual has coverage under two or more health plans.

Answer: They do consider that HCFA must specify a national COB standard, but it is for establishing formats for collecting data, not imposing substantive ordering priorities for the coordinating plans. They are not going to develop an ordering model, but will stick with data collection, leaving the substantive requirements to the states and the courts. (See Attachment)

5. Please summarize the progress and projected time table for implementation of HCFA's establishment of standards and requirements for electronic transmission of health information, as mandated by HIPAA.

Background: HIPAA authorizes HCFA to develop a "unique health identifier" (similar to a social security number or taxpayer identification number) for each individual, employer, health plan and health care provider for use in the health care system. HIPAA also authorizes HCFA to develop standards for transactions (and data elements for such transactions) to enable health information to be exchanged electronically. In addition, HIPAA authorizes HCFA to adopt standards for electronic transmission of such data and to establish rules for the wrongful disclosure of individually identifiable health information.

Answer: The Department of HHS, not HCFA, is dealing with standards under the administrative simplification project. The standard most commonly used for pharmacy plans, where the pharmacy collects the deductible, works well and will probably be deemed the standard for pharmacy. For other type of benefits, Medicare and Medicaid are 90% automated, and Blue Cross/Blue Shield is about 70% automated. Other insurers and third party administrators are hardly automated at all, and have a lot of capital investment in their systems. They are somewhat reluctant to force them to become automated. They were hoping to have payor and provider regulations out by February, but there are still some unresolved issues.

It is more complicated to come up with an individual number. One option is the social security number, but many are opposed to that, including the SSA.

They need to make sure there is a "check-digit" in each number, and there are international standards for that. They are considering using EINs, and other numbers already available wherever possible.

They are looking at privacy issues, as required. If Congress doesn't specifically act, they will have 6 months to issue regulations. They don't see HCFA using the internet due to privacy concerns.

6. Will the certificate of creditable coverage (which is required by HIPAA) need to be filed with HCFA as part of the national health database described in Question 5?

Answer: No, the certificate of creditable coverage will not have to be filed with HCFA. In any event, they don't think that the data will be stored by HCFA. Rather, HCFA will set standards for the transmission of data. Data itself will not go to HCFA or Department of Labor. Later on, they might want claims data in order to develop standards, but they don't see that for now due to the lack of automation in the claims processing industry. They will pursue this, and other issues, with Internal Revenue Service and Department of Labor.

7. What is the document retention requirement for employers regarding the certificate of creditable coverage?

Answer: They don't think the creditable coverage rules created a separate document retention requirement. The ERISA standard (6 years) or those of the various states would be whatever applies based on the entity. They don't think they would want to standardize that, since HIPAA is an overlay onto (and not a substitute for) the Code, ERISA, state law, etc. They will pursue this with Internal Revenue Service and Department of Labor.

8. This question is regarding the HCFA regulations under 42 CFR 417.151 et seq. In general, that regulation requires an employer that includes both one or more qualified HMOs and a non-HMO alternative in its health plan to make employer contributions to an HMO in an amount which does not discriminate financially against an employee who enrolls in an HMO. The

regulation sets forth various methods of employer contributions which will be considered nondiscriminatory. Assume an employer offers many HMO alternatives (e.g., six different HMOs in a single geographic area), but offers only one non-HMO alternative. Does the employer contribution for each HMO alternative have to be in a nondiscriminatory amount compared to the non-HMO alternative or would the employer comply with the regulations if the employer contributions for one or more, but not all of the HMO alternatives were nondiscriminatory compared to the non-HMO alternative?

Answer: They believe that the financial non-discrimination rules apply to all federally qualified HMOs. The non-federally qualified HMOs are not protected by those rules.

9. What is the current status of the declaratory relief and repayment MSP case brought in the D. C. District Court by Aetna and CIGNA?

Answer: The Complaint has been filed and answered. A conference was held on April 25th but the report of that conference has not been filed by the court and as of May 6, 1997, the briefing schedule has not been set.

10. What is the current status of the National Medical Care ESRD-MSP case?

Answer: The case relates to a retiree (such that Medicare is primary) who later develops ESRD (which would normally trigger Medicare being secondary for 18 months). HCFA initially issued a policy statement as a result of a 1993 change in the MSP statute requiring plans to become primary for the 18 month coordination period. Soon thereafter, HCFA revised its policy so that the coordination period would not apply if Medicare was already properly primary because HCFA realized that changing the plan's status only for those with ESRD would be "taking Medicare into account, which is prohibited under the law."

NOTE to JSH: Missing one line (at least) and one page, or portion thereof.

11. What is the status of HCFA's instructions for contractors to use to process refunds due as the result of the decision in Health Insurance Ass'n of America et al v. Shalala, 23 F.3d 417 (D.C. Cir. 1994), cert. denied, 115 S. Ct. 1095 (1995)?

Answer: They have had refund instructions since before the HIAA decision. However, those refund instructions will require changes in part because of a need to couple the refund process with the demand and offset process required by the Debt Collection Improvement Act. The policy decisions are moving along well, but the systems decisions are extremely difficult. Therefore, these instructions may not be issued for a while.

12. Does HCFA have any plans to expand the scope of the Indirect Payment Procedures, as set forth at §7065 of the Medicare Carriers Manual?

Answer: In general, Medicare only makes payment to providers or beneficiaries. HCFA developed the Indirect Payment Procedure to allow Medicare payments to be an entity, like an HMO and other managed care organizations, under which the beneficiary has no copayment or deductible responsibility but the entity has to meet the Medicare deductibles and copayments. The Indirect Payment Procedure has not been the subject of recent policy development.

13. Has HCFA created an exhaustive list of categories of "similarly situated" individuals, as defined in 42 C.F.R. §411.101?

Answer: The preamble to the Final rule published on August 31, 1995, included examples of categories of individuals that could be considered to be "similarly situated." These examples were not intended as an exhaustive list and for this reason, HCFA has not developed such a list. HCFA will analyze plan action creating categories of allegedly "similarly situated" individuals on the basis of both the intent of the plan and the effect of the plan provisions. For example, suppose a plan includes a provision that requires termination of domestic partner if he or she obtains other coverage, and that plan does not have a similar coverage limiting provision for any other category of individuals covered under the plan. On its face, the provision would not seem to improperly "take Medicare into account" because it applies to all forms of other coverage, not just Medicare. However, if it turned out that only disabled Medicare beneficiaries lost coverage under the plan, HCFA could find the provision to be improper in effect, even if it were not intended to apply only to disabled Medicare beneficiaries.

14. Does the concept of "similarly situated" apply to those entitled to Medicare solely on the basis of ESRD or age? Please describe the interaction between 42 C.F.R. §411.108(a)(4) and (5).

Answer: The concept of "similarly situated" in 42 C.F.R. §411.108(a)(4) only applies to disabled Medicare beneficiaries. Other MSP provisions prohibit discrimination against aged and ESRD Medicare beneficiaries as a result of their Medicare coverage, as generally described in 42 C.F.R. §411.108(a)(5). For example, suppose a plan adopts a provision to terminate coverage for any

domestic partner who develops ESRD. This would violate §411.108(a)(5) because it limits coverage to Medicare entitled individuals by a provision that does not apply others — because virtually all individuals who develop ESRD become entitled to Medicare. However, a provision that terminates coverage for a domestic partner who obtains other coverage, as reviewed in the answer to question 13, might not violate §411.108(a)(5).