QUESTIONS AND ANSWERS WITH HCFA

1. Cafeteria Plans. Last year we asked you the following questions about the interaction between the Medicare Secondary Payor laws and Cafeteria Plans under Section 125. Those questions, and our writeup of the answers, are listed below. Have your answers changed in any way? Have you given any further thought to l.c., below, a situation where a choice is offered between two or more non-taxable benefits, only some of which are health benefits, and under which Section 125 of the Code is not needed in order to make whatever benefit is chosen non-taxable?

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?

1997 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.

1998 Answer: Pretty much anything that is permissible under 125 is okay and this is a good public policy and it will not be considered an impermissible incentive under MSP. They have now released a letter taking this position in writing.

ii. 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?

1997 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.

1998 Answer: If it’s okay under 125, then there is no MSP implication

iii. What if it’s choice of non-taxable benefits not covered by Section 125?

1997 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.

1998 Answer: They haven’t really thought about this issue much since last year. But they will think about it and get back to us.

1998 Post-Meeting Followup Answer: They are still considering this, but they have serious concerns about exempting something with no specific statutory scheme to evidence Congress’ intent that there be an exception.

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.

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?

1997 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.

1998 Answer: Since health flexible spending accounts are permissible under section 125, their position is the same, that the accounts will not be subject to the MSP rules. These accounts are the participants’ own money, and they do not think it would be proper policy to make the participant apply the accounts to the medical bills before Medicare had to pay.
2. Individual Policies. Regarding the states' responsibilities for enforcing group-to-individual portability for individual health insurance coverage under HIPAA:

a. 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: Only Missouri and Rhode Island have notified HCFA that they intend to rely upon the federal default provisions. A table setting forth mechanism adopted by other states as of the meeting date was distributed and is attached. Since the law did not require the states to inform HCFA of the action they intend to take, complete information has not been collected. HCFA has not heard from: Arizona, Colorado, Delaware, Hawaii, Maryland, Missouri, North Carolina, Rhode Island, Tennessee, or West Virginia.

40 States submitted alternative mechanisms and all were found acceptable. Massachusetts and Virginia have not yet enacted legislation, but it is still pending and they have not notified HCFA of any failure to comply. Kentucky is planning to do a state mechanism, but has had a legislative delay.

b. Which states will require federal enforcement of the default requirements, and which states will enforce those requirements themselves?

Answer: The law does not require states to notify HCFA that they intend to rely upon default provisions and most have not stated their intention. Only Missouri and Rhode Island have notified HCFA that they intend to rely upon the federal default provisions. HCFA may also have to assume that responsibility in California. California had notified HCFA that it would rely on a state alternative. However, California failed to enact such legislation and so advised HCFA. Therefore, at this time it appears that HCFA may assume responsibility for California. Also, legislation failed to pass in Maine and Michigan. Neither, however, has notified HCFA that it should undertake enforcement responsibilities in those states.

Missouri and RI did not submit an alternative mechanism for either group or individual markets, and has so notified HCFA, so HCFA is enforcing everything in those states. RI had some portability even better than HIPAA, but the legislature failed to make the necessary changes to comply exactly.

c. 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? Would it enforce that state's alternative mechanism or the federal default provisions?

Answer: If a state does not adopt its own conforming alternative then the default applies. The statute requires HCFA to make a determination regarding a state's compliance and to take several steps before it assumes responsibility. These include notice to the state that it does not conform to section 2741 requirements. HCFA has to make a determination as to whether and when the federal provisions go into effect.

HCFA is responsible for the entire market if the state is not involved. Even so, as a matter of policy HCFA will try to work with the state. Only where the state laws do not afford protections equal to the federal standards will HCFA get involved. Intervention is a sensitive issue. There are many reasons not to interfere with the state's efforts. California, however, sent letter requesting HCFA enforcement in individual markets. That effort will be coordinated with the state authorities.

HCFA anticipates working with each state's department of insurance and reviewing the state's laws that relate to HIPAA requirements. As an example of the difficulties recognized to coordinate state authorities, HCFA cited California where the agencies with jurisdiction are more numerous. Among the California agencies that would need to be coordinated are the Department of Corporations, the Department of Insurance, the Governor's Office and the Health Department. As an example of the variety of issues that may arise from different state laws, HCFA cited Rhode Island. There, the law required some individual to individual portability requirements but had prudent person standards for pre-existing conditions [acs] rather than the HIPAA standard of a "provable and diagnosed" condition. In Missouri, as another example, there is regulation of the small group market for both a basic and a standard policy. The small group is defined to be a group of 3 to 25 persons, not the federal definition of 2 to 50 persons in a group. HCFA recognized that this would require a different type of coordination than where there is no state regulation.

Today, the regional offices are dealing with consumer complaints. These experiences are forming the basis for some policy review in the Kansas City and Boston Regional Offices.

3. Individual Policies. Much publicity has been given to insurance company practices tending to discourage the sale of HIPAA-mandated individual coverage, such as paying reduced or no commissions.

a. What actions is HIPAA taking to prevent subversion by insurance companies of the group-to-individual portability requirements? Are states going to be helpful in stopping these practices, or is direct HCFA intervention with the insurers going to be necessary?
Answer: HCFA prefers to issue guidance to states that are enforcing the law, and states have been helpful. HCFA does not itself enforce regarding commissions, but relies on the states to regulate such matters. HCFA referred to its Program Memorandum, Transmittal No. 98-01 wherein it gave notice that it has received complaints and is currently investigating whether insurers are discouraging access to individual and small group policies by paying low commissions compared to other products and are attempting to frustrate applicants by unreasonable delay in the issuance of policies. HCFA warned that it has enforcement authority including the assessment of a civil penalty of one hundred dollars per violation per day. If its guidance doesn’t address the issue, intervention with the issuers may be forthcoming but they are hoping it won’t be necessary.

b. Are there any jurisdictional problems with HCFA intervening on a single issue if the state is otherwise enforcing HIPAA’s provisions?

Answer: No. However, this will require coordination with the state enforcement agencies. They have to make a specific finding that people aren’t getting their rights in a state, before they can go in. In the group market, HCFA can go in if the state doesn’t enforce “a” requirement. On the other hand, in the individual market, HCFA can only go in if the state fails to enforce “the” requirements, so the difference in statutory provisions has created some confusion. But in general, there is no requirement that the states report to HCFA unless they want approval of an alternative mechanism, so getting information on which to base intervention may be difficult.

c. Have any insurers withdrawn from the individual market altogether (while still writing other health insurance) rather than comply with HIPAA’s requirements?

Answer: Blue Cross of New Hampshire is the only one they know has withdrawn, and where it is possible that the withdrawal is due to HIPAA, although its reasons are not really known. They’ve talked with some others to help them work out ways of complying. HCFA is not aware of any causal relationship. In addition to Blue Cross of New Hampshire, it has also heard that a large insurer has withdrawn from the individual market. Again, the reasons are not known for that decision.


a. As with individual policies, are states implementing alternative mechanisms or following the default provisions?

Answer: Of the group market provisions, only guaranteed availability is different for small business than from every other plan. There is no alternative mechanism for these provisions, so the question doesn’t make any sense.

There is also a provision in the statute requiring some studies, and they are doing those studies.

b. Have any enforcement problems arisen, either with getting the states to enforce the provisions or with insurance company practices to discourage the sale of the policies?

Answer: Only Missouri and Rhode Island have announced failure to enact small group market legislation. HCFA may only act where responsibility has fallen to it by notice. The statutory basis for jurisdiction depends upon a finding of non-enforcement or where HCFA is invited in by notice. See Program Memorandum, Transmittal No. 98-01 for Agency position related to certain issuing practice

c. Have any insurers withdrawn from the small business market altogether (while still writing other health insurance) rather than comply with HIPAA’s requirements?

Answer: John Alden has announced that it isn’t taking late enrollees in the small group market and both Principal and John Alden have voiced some concern about the small group market. HCFA has heard rumors of companies considering getting out, but is not directly aware of anybody getting completely out of the small group market.

5. Rate Increases. Periodically since HIPAA was enacted, we read of horrible rating practices (mostly under individual policies), many involving rate increases of 300%, 500%, etc. Nothing in the legislative history seems to indicate whether the Congress anticipated the practice and assumed that the states would regulate it. Was the legislative intent underlying HIPAA to not address the matter on the federal level in the expectation that the states would do so? Is there any attempt under way of a unified, national approach to the matter.

Answer: At this point, they are just gathering information and collecting stories. They have not made any decisions as to whether they will take action. It’s largely political, and they aren’t even sure they know what is an excessive rate and on what type of rate pool the HIPAA-protected policies should be based.

HIPAA does not view its mandate as to have the federal government setting rates. Yet, rating practices are material to compliance with coverage requirements. HCFA will monitor industry practices to assure that rating is not used to avoid the required coverage. Today, however, the Agency is only gathering information, it is not taking any action at this point. It was also noted that it is not clear what Congress intended or what states are doing in this area. There is no uniform action. It was also noted that it is far from clear what constitutes an outrageous premium. Insurers will
explain that an applicant’s medical history does not make a particular increase outrageous. This is an area fraught with difficulties for HCFA to administer. Congress only wanted to address access, but access only at high premium costs is not access at all. They recognize, however, that there is some point at which the amount of the increase becomes abusive, because prohibitively high premiums would result in no access. It is likely that more than a 200% premium increase (the NAIC risk pool cap) would likely be scrutinized.

6. Non-Federal Government Plans. Regarding the states’ plans’ options for either complying with HIPAA or opting out with respect to the employees of state and local governments, how many plans have opted out? Are all plans in a single state doing the same thing (either opting out or staying in), or within a state are different plans tending to take different actions?

Answer: There are approximately 600 state and local government plans that have elected out of HIPAA. They don’t know who the plans are or how many of them there are until they come in and file an election, so they don’t have the data on which to determine patterns. Thus, HCFA’s data does not indicate whether there is consistency within a particular state.

7. Identifiers. Has HHS made progress since last year in selecting a workable “unique health identifier”?

Answer: They will issue fairly soon a notice of intent to propose an identifier without proposing any specific identifier. The Employer identifier will be the Federal tax identification number. The Health Plan identifier will be the HCFA payor number issued by HCFA. A standards board initially listed about 6 choices, but they have found others, and the notice will list around 20 possibilities and ask for comments from the public. It’s likely to be published this summer and have a 60-day comment period. If possible, they will then issue a notice of intent to propose regulations, proposing a specific identifier.

Identifiers for each individual has been controversial. There appears to be no public consensus as to what identifier should be used. HCFA will issue a Notice of Intent and explain the options that are being considered (a total of 20 options). HCFA will not make any recommendation in this Notice. These twenty (20) options will be outlined and the Notice will request public comment. The Notice is in the department clearance stage and will then go to OMB. The notice will probably be issued in approximately 60 days. After review of public comments, HCFA will issue a Notice of Proposed Rulemaking.

8. 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: No Answer.

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.

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?

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

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 a. change?

**Proposed Answer:** 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.

c. Assuming that issuers of stop-loss policies are not required to comply with HIPAA, will they be permitted to interfere with the ability of the plan to comply by refusing to cover things that the plan itself must cover?

i. In the case of the requirement to supply certificates of creditable coverage, the cooperation of the stop-loss insurer is not an issue, since the employer and the plan will have that data.

ii. Could a stop-loss carrier, in effect, impose its own pre-existing condition exclusion period by refusing to reimburse the plan or the employer for benefits due to a person during the early period of plan participation regardless of whether the person had a certificate of creditable coverage from a prior plan?

iii. Could a stop-loss carrier refuse to reimburse for complications of pregnancy? For expenses of covered newborn children? For those whom it deems not to be insurable at the time of entry into the plan?
Proposed Answer: Although the stop-loss carrier is not responsible for certificates of creditable coverage, and not responsible for determining whether the plan complies with HIPAA, it cannot carve out HIPAA-mandated coverages and refuse to reimburse for its portions of those expenses.

Answer: They cannot answer these questions at this time. Court cases are pending and DOL is heavily involved, so they have been asked not to comment. Some states are tapping stop loss as part of the assessment base for their risk pools. Some people think that the definition of “issuer” might include stop-loss carriers in some cases.

10. Medicare Secondary Payor. A key executive of a company has semi-retired, switching to part-time status. Part-time employees (regardless of their age) are not eligible for any benefits, including health insurance. He wants to only work part-time so that the amount of his compensation does not reduce his Social Security benefits. The employer would like to pay the employee’s Medicare premiums, and/or purchase a Medigap policy for him.

a. Would such a payment violate the rule that prohibits any payment inducing a person to select Medicare as his primary insurer rather than the employer’s plan?

Proposed Answer: No. Paying Medicare premiums and providing a Medigap policy does not violate the MSP “inducement” rules, because he is not eligible to participate in the employer’s health plan due to his part-time status. Those rules only apply to individuals eligible for the plan.

Answer: HCFA disagrees with this proposed answer. If the employer pays either the Medicare premium or for a Medigap policy, the employer is establishing a “plan” that must be primary to Medicare. Payment of the premiums or for the policy would be found to violate the prohibition on financial incentives not to enroll in a group health plan.

If there is a Medigap policy, then he is actually eligible to participate — it’s just in a different plan than the big plan, so the Medigap supplement would be prohibited. However, if there is no Medigap coverage, and he isn’t eligible for the big plan, then paying the Medicare Part B premium is not a problem.

b. Would the payment of the Medicare premium for a part-time individual and/or the payment of premiums for a Medigap policy, constitute a “plan” sponsored by the employer due to the individual’s current employment status?

Proposed Answer #1: No, because the employer has a plan and the individual is not eligible for it due to his part time status. The employer’s payments for his Medicare premium and his Medigap policy are completely outside the scope of the employer’s plan.

Proposed Answer #2: Yes, because the only reason the employer is willing to make these payments is that the individual is an employee (albeit a part-time employee). If he were simply to quit, the employer would not continue to make those payments. Since the payments are being made solely because of the employer’s current part-time employment status, they constitute a second plan maintained by the employer, which itself is subject to the MSP working aged rules since the employer has more than 20 employees. As such, provision of a Medigap policy would place the plan in violation of the “taking Medicare into account” rule. Any separate plan of the employer for part-time employees must be primary to Medicare if it is based on their current employment status.

Answer: Proposed Answer 2 is correct. The Employer can pay the Part B premium or for a Medigap policy only if there is no plan.

c. Suppose that instead of covering the employee as a part-time employee, the employer adopted a retiree program just for that employee, and treated him as having retired from full-time employment even though he is still working part-time. Could the employer pay Medicare and Medigap premiums for that employee under such a “retiree” plan, even though the employee has never ceased employment but rather just ceased full-time employment?

Proposed Answer: If an employee is covered by a bona fide retiree plan, and he returns to work at a level below what entitles him to regular plan coverage, he can stay in the retiree plan and Medicare will continue to be primary with the retiree plan being secondary. There should be no difference because the employee did not fully retire and return, so long as the employer intends to continue the policy in force even after the employee is not working at all.

Answer: If a reemployed annuitant with retiree health insurance comes back to work part-time, he is allowed to continue in the retiree plan with Medicare remaining primary, so long as he doesn’t qualify for any plan covering people by virtue of current employment status. They have trouble imagining a situation where you would qualify for a retiree plan without actually retiring, but if the terms of the employer’s retiree plan really allowed people who qualified for the plan by virtue of past service, or whatever, to get into that whether they fully retired or just reduced their hours below the regular plan’s level, then the analysis would be based on whether the coverage was or was not “by virtue of current employment status.” If he truly has coverage by virtue of having qualified for the retiree plan and having ceased to qualify for any active plan, and if he would have the exact same coverage even if he was not working part-time, then presumably the coverage is not by virtue of current employment status and is permissible with Medicare being primary.
d. In c., does it matter that the individual being covered by the “retiree” plan is a senior executive, whose hours are not monitored? What if the employee, while being paid at a level of hours below what would be covered by the regular plan, actually works more hours such that he should be entitled to coverage under the regular plan. Does HCFA look behind the employer’s designation to make sure that the employer hasn’t called someone a returning retiree when he is really a full-time employee, just to keep the plan covering him secondary to Medicare?

**Answer:** Enforcement of the MSP provisions is within HCFA’s discretion, with the actual enforcement actions carried out by the appropriate Medicare contractor. MSP is basically run as an honor system. Their basic rule is “thou shalt not cheat.” Some contractors probably monitor more carefully than others.

11. **Retiree Plans and HIPAA.** A plan is not subject to HIPAA if all of its covered people are retirees and their dependents, since a requirement for being subject to HIPAA is having at least two participants who are active employees, and a retiree plan typically would not meet that requirement.

Suppose an employer allows its retirees to return to work part-time, and keeps them in the retiree plan so long as they are working at a level that would not qualify them for coverage under the active plan. We know that under the MSP rules this practice (at least, if *bona fide*) is permissible, and will not make the retiree plan primary to Medicare since their coverage is as retirees (albeit retirees who have returned to work part-time), and not as active part-time employees.

But will the same result apply under HIPAA? Or will an employer that allows two or more of its retirees to work part-time find the retiree plan subject to HIPAA, since the plan now covers two or more individuals who happen to be active employees (albeit part-time employees), even though they are not getting their coverage as a result of their current employment status but are only getting coverage because they have retired.

**Answer:** They have been asked not to comment, since it’s a 3-agency issue.

12. **Emergency Medical Treatment and Active Labor Act (EMTALA).** The following questions and answers relate to the interpretation and applicability of EMTALA to the provision of liver transplants or other elective organ and tissue transplants. At present, there do not appear to be any regulations or case law dealing with these specific issues, although the issues have become a matter of practical concern for tertiary hospitals providing organ and tissue transplant;

An illegal alien who is indigent, uninsured and ineligible for Medicaid or Medicare is admitted to the emergency room of a community hospital with a diagnosis of end-stage liver disease. She is treated and stabilized without surgery. In recognition of the fact that the stabilization procedures were not curative, but rather palliative, and that her disease will imminently progress to a life threatening stage without a liver transplant, the patient is transferred to a transplant center. The transplant center is located approximately 75 miles away, in another county. Although there were closer hospitals with liver transplant programs, no other transplant center would accept the patient.

Prior to accepting the transfer of the patient, the transplant center requires that the community hospital guarantee payment of the costs of medical treatment to be rendered to the patient (at Medicaid rates). It is also agreed that if the patient is deemed medically ineligible for transplant, she will be referred back to the transferring hospital for further treatment.

The patient is found to be eligible for liver transplantation. A compatible liver is located in time, despite the shortage of such organs, and the patient is successfully transplanted. When the transplant charges, exceeding $200,000, are submitted to the community hospital, the community hospital refuses to pay.

a. Has the community hospital violated the provisions of EMTALA, by transferring he patient to the transplant center and then refusing to pay the cost of the transplant services?

b. Is the provision of a liver, organ or tissue transplant required by EMTALA’s definition of an emergency?

c. Has the transplant center violated the provisions of EMTALA by charging the transferring hospital for the organ transplant services?

d. Does a transplant center have a duty to accept the liver transplant candidate under these circumstances? If so, is there any requirement that the candidate be transferred to the center most geographically proximate to the transferring hospital?

**Proposed Answers:** Where the transferring hospital has stabilized the patient before transfer, the emergency has (by definition) been abated and eliminated and EMTALA is not applicable. (Implicitly, if the patient is capable of being transported, the patient is stable and the immediate emergency has been alleviated). Therefore, because EMTALA is not applicable to non-emergent situations, neither hospital, in the above scenario, has violated EMTALA. Further, the agreement guaranteeing payment for transplant services is valid and enforceable and is not violative of EMTALA. 42 U.S.C. § 1395 dd, et seq. And 42 C.F.R. §§ 489.24 et seq.
Even if the patient could not be stabilized (or if the patient had originally been directly admitted to the transplant center), EMTALA does not require that organ or tissue transplants or other elective procedures be rendered to abate an emergency. Stabilization and palliation are all that is required by EMTALA. Services beyond basic life support are not required to be provided under EMTALA.

EMTALA requires a hospital to provide only those services which will stabilize the patient. It does not require the hospital to treat the underlying disease. 42 U.S.C. §§ 1395 dd(b) and (e) 42 C.F.R. §489.24 (a),(b) and (c)(1). Furthermore, EMTALA is designed to address organized service units that provide specialty care for commonly occurring traumas, such as burn units. It does not apply to highly exceptional procedures such as organ transplants which cannot be performed for every patient experiencing an organ failure. 42 C.F.R. §489.24(c).

Where transfer is required by EMTALA, the transfer must be effected with regard to safety and cost. Ordinarily, the most geographically proximate transfer will also be the most safe and the least costly. A transfer to a more distant hospital potentially exposes the patient to enhanced risk and ordinarily results in a delay in obtaining treatment, thereby jeopardizing the health and safety of the patient.

Transferring patients to more distant locations, also has the effect of geographically isolating the patient from the patient’s family and support system while the transplant is being performed and then isolating the patient from the necessary supportive after-care providers and facilities, after the patient is discharged. Although such travel may be necessary where there is no closer facility, where there is a closer facility, logic dictates that the closer facility be selected for transfer.

Moreover, selection of a local facility is more rational from a financial standpoint as well. It prevents the uneven distribution of patients and an irrational spread of financial risk. To grant the referring hospital unfettered discretion would permit richer suburban hospitals to transfer their patients to impoverished urban areas with impunity. Additionally, it would allow certain tertiary care centers to gain unfair economic advantage by accruing patients from distant areas by providing financial incentives to transferring hospitals or ambulance operators.

Furthermore, selection of an institution must be based on geographical proximity to the transferring patient in order to avoid a host of problems may arise for the patient in obtaining third party payment or reimbursement for the care rendered at the tertiary care center. For example, the transfer is more likely to be outside the service area of the HMO or managed care organization, if the transfer is based upon something other than proximity to the transferring hospital or the patient’s residence. State Medicare reimbursements, which are often linked to the County of residence of the patient would be imperiled.

Answer: No answer at this time. They individuals in charge of this area will respond in writing when thy are clear on their response.

13. 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: The IG would be the one to respond, and the IG’s office was not present.

14. HIPAA Non-Discrimination Rules. Will the following common practices be prohibited by HIPAA when the final regulations are issued:

a. Caps on organ transplants? If so, does it matter whether the cap is in the $1-200,000 range, which does at least provide some significant coverage for a transplant, as opposed to the $5-40,000 range, which is meaningless for most transplants?

b. Exclusions for self-inflicted injuries (which are viewed by many as discrimination against depressed people)?

c. Exclusions based on how an injury was received, such as motorcycle injuries, injuries while flying or riding in a non-
scheduled aircraft, bungee jumping injuries, injuries to a child not properly seat-belted in an automobile, injuries to the passenger of a drunk driver?

d. Lifetime caps on all benefits under the plan?

Answer: No answer do to 3-agency regulation development efforts.

15. Mental Health Parity Act.

a. Can a plan limit the number of outpatient visits per year and also place a dollar cap on the amount that will be paid for each visit — thus effectively but not directly placing an annual dollar cap on payments for outpatient visits?

Answer: Yes.

b. Similarly, can a plan limit the number of inpatient hospital days per year and also place a dollar cap on the amount that will be paid for each day — thus effectively but not directly placing an annual dollar cap on payments for inpatient visits?

Answer: Yes.


a. When does the 48/96 hour period begin to run and when do the protections end? Does the protected period ever start before birth (such as on admission to the hospital)?

Answer: Hopefully, regulations will be issued this summer. It is unlikely that the period will ever start before birth.

b. Can the protections end at an inconvenient time, such as 3 a.m., and thus induce the mother to leave the hospital the previous evening in order to avoid the inconvenient departure time?

Answer: It is likely that they would regard it as abusive to force a 3 a.m. discharge.

c. Can a plan provide an incentive for a mother to give birth outside of a hospital setting, and thus not enter the hospital? (For example, could the plan provide 100% coverage if the birth is at home attended by a mid-wife, but require a 20% co-payment if the mother or the child is admitted to the hospital at any time during the 48/96 hour protected period?)

Answer: They don’t have a definite answer, and we’ll have to wait for the regulations. But they don’t think this would be allowed.

Followup question: What is a hospital in a situation where the hospital has an upscale Holiday Inn on its premises? Can they move the mother for part of the protected period into the Holiday Inn, which would be cheaper? They haven’t addressed things like this.

17. Medicare Secondary Payor. Do the Medicare secondary payor rules apply to a plan that covers only self-employed individuals?

Proposed Answer: They do not because such a plan is not a group health plan, and employment status for this purpose is determined using the common law test, consistent with the Supreme Court’s decision in Nationwide Mutual Ins. Co. v. Darden, 503 U.S. 318, 323 (1992), despite the federal district court decision in Therkelsen v. Shalala, 839 F. Supp. 661, 667 (D. Minn. 1993).

Answer: If the plan is solely for self-employed persons, it does not, in HCFA’s view, constitute a group health plan under Section 5000 of the Internal Revenue Code. However, if the self-employed are covered under the same plan as everyone else, then the plan as a whole is a group health plan, and the MSP rules apply to them as well as to the common law employees.
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dear [Name],

You have inquired whether an employer who offers employees cafeteria plan options which include alternatives to employer-sponsored group health plan coverage violates the MSP provisions in Section 1862(b)(3)(C) of the Social Security Act. Specifically, this law prohibits an employer from offering an individual entitled to Medicare any financial or other benefits as an incentive not to enroll in, or to terminate enrollment in, a group health plan (GHP) which would otherwise be primary to Medicare. The law imposes civil monetary penalties on employers that violate this law. Please excuse the delay in my reply.

Section 125 of the Internal Revenue Code (IRC) allows employers to maintain cafeteria plans under which employees may choose among certain taxable and non-taxable benefits. Cafeteria plans are advantageous to employees because they enable employees to purchase benefits on a pre-tax basis as opposed to an after-tax basis. For example, under a flexible benefit account, employees are able to utilize pre-tax dollars to pay their share of any insurance premium, to pay deductibles and coinsurance amounts under health benefits plans, or to pay medical bills, such as orthodontia, which may not be covered by the employer's plan. Flexible benefit plans have also been utilized by employers as vehicles to get away from providing extremely expensive employee benefit plans to all employees. They have also been a way for an employer to introduce new benefits such as dependent care benefits or dental coverage without increasing the overall cost.

It is the Health Care Financing Administration's policy that if a beneficiary for whom Medicare would be secondary payer elects a benefit offered under the employer's cafeteria plan, i.e., one which meets the requirements of section 125 of the IRC, in lieu of the employer's GHP, the employer would not be in violation of the MSP provision cited above. It obviously was not the intent of Congress to impose civil monetary penalties under the Medicare law on employers that enjoy the tax benefits available under the cafeteria plan provisions of the IRC.
We plan to codify this policy in federal regulations as soon as possible. I hope this information adequately addresses your concerns. If you have any further questions, please call [redacted] of my staff at [redacted].

Sincerely,

[Signature]

Bernadette Schumaker
Deputy Director
Division of Integrated Delivery Systems
### CHARACTERISTICS OF ALTERNATIVE MECHANISM SUBMISSIONS

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**Legislation necessary to implement Alternative Mechanism has not passed legislature.**
## medicare

### Carriers Manual

#### Part 3 - Claims Process

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The Medicare Secondary Payer (MSP) instructions have been renumbered and organized to eliminate duplicative material. They obsolete §§IM3336 (IM-90-2) and §§IM3341-IM3341.8 (IM-93-1). The instructions also have been updated to incorporate MSP provisions contained in OBRA 1989, 1990, and 1993 as well as the Social Security Act Amendments of 1994. The changes in these laws were published in final regulations on August 31, 1995.

### CLARIFICATION—EFFECTIVE DATE: Not Applicable

**Section 3322. Charges by Relative or Member of Immediate Household**, was previously numbered §3325.

**Section 3323. Duplicate and/or Overlapping Bills With Discrepant Charges**, was previously numbered §3328.

**Section 3324. Evidence of Medical Necessity for Parenteral and Enteral Nutrition**, was previously numbered §3329.

**Section 3328.16. TPP Pays Primary Benefits When Not Required**, was previously §3336.16 and clarifies that it is the responsibility of the TPP to ask the beneficiary to request the submission of a claim when the TPP paid primary benefits when not required, and no Medicare claim was submitted for the service. The time limit may be extended under §3004.1 only if failure to file timely resulted from error or misrepresentation by the Medicare program.

**Section 3328.17. Federal Government's Right to Sue and Collect Double Damages**, was previously §3341 and has been renumbered with minor changes.

**Section 3329.6G. Documentation of Conformance**, gives examples of acceptable documentation that a GHP or LGHP can use to demonstrate that it has complied with the nondiscrimination rules.

*HCFA-Pub. 14-3*
3328. MEDICARE SECONDARY PAYER (MSP) GENERAL PROVISIONS

A. Introduction.--Under the Medicare law, as enacted in 1965, Medicare was the primary payer for Medicare covered services except for services covered by workers' compensation (WC). In 1980, Congress enacted the first of a series of provisions that made Medicare secondary payer to certain additional third party payers (TPP). The purpose was to shift costs from the Medicare program to private sources of payment. The MSP provisions are found in §1862(b) of the Act. At present, the law makes Medicare secondary payer to insurance plans and programs in the following situations:

1. Working Aged.--Medicare is secondary to group health plans (GHPs) of employers and employee organizations, including multiemployer and multiple employer plans which have at least one participating employer that employs 20 or more employees. Medicare is secondary for Medicare beneficiaries age 65 or older who are covered under the plan by virtue of their own current employment status with an employer or the current employment status of a spouse of any age. (See §§3336ff.)

2. Working Disabled.--Medicare is secondary to large group health plans (LGHPs), i.e., plans of employee organizations and employers when at least one of the employers employs at least 100 employees. Medicare is secondary for Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and are covered under the plan by virtue of their own or a family member's current employment status with an employer. (See §§3337ff.)

3. End Stage Renal Disease (ESRD).--Medicare is secondary to GHPs (without regard to the number of individuals employed and irrespective of current employment status) that cover individuals who have ESRD. Except as provided in §3335.4E, GHPs are always primary payers throughout the first 18 months of ESRD-based Medicare eligibility or entitlement. (See §§3335ff.)

4. Workers' Compensation.--Medicare is secondary to WC plans (including black lung benefit programs) of the States and the United States. (See §§3330ff.)

5. No-Fault.--Medicare is secondary to any no-fault insurance, including automobile medical and nonautomobile no-fault insurance. (See §§3338ff.)

6. Liability.--Medicare is secondary to any liability insurance (e.g., automobile liability insurance and malpractice insurance). (See §§3340ff.)

When Medicare is secondary payer, the order of payment is the reverse of what it is when Medicare is primary. The other payer pays first and Medicare pays second. This means that the provider, supplier, or beneficiary must first submit the claim to the primary payer, which is required to process and make primary payment on the claim in accordance with the coverage provisions of its contract. The primary payer may not decline to make primary payment on the grounds that its contract calls for Medicare to pay first. If, after processing the claim in this manner, the primary payer does not pay in full for the services. Medicare secondary benefits may be paid for the services as prescribed in §3328.18. Generally, the beneficiary is not disadvantaged where Medicare is secondary payer because the combined payment by a primary payer and by Medicare as secondary payer is the same as or greater than the combined payment where Medicare is primary payer.

B. Definitions.--

2. **Conditional payment** means a Medicare payment for services for which another insurer is primary payer.

3. **GHP** means any arrangement of, or contributed to by, one or more employers, or employee organizations, to provide health benefits or medical care directly or indirectly to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. An arrangement by more than one employer is considered to be a single plan if it provides for common administration of the health benefits (e.g., by the employers directly or by a benefit administrator or by a multiemployer trust or by an insuring organization under a contract or contracts).

A plan that does not have any employees or former employees as enrollees (e.g., a plan for self-employed persons only) does not meet the definition of a GHP, and Medicare is not secondary to it. Thus, if an insurance company establishes a plan solely for its self-employed insurance agents, other than full-time life insurance agents, the plan is not considered a GHP. However, if the plan includes full-time life insurance agents or other employees or former employees, it is considered a GHP.

The term "GHP" includes self-insured plans, plans of governmental entities (Federal, State and, local such as the Federal Employees Health Benefits Program), and employee organization plans. Examples of the latter are union plans and employee health and welfare funds. Employee-pay-all plans are also included (i.e., GHPs that are under the auspices of one or more employers or employee organizations but do not receive any contribution from the employer). However, coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is secondary to Medicare since the law makes Medicare primary to CHAMPUS.

Any health plan (including a union plan) in which a beneficiary is enrolled because of his/her own employment or a family member's employment meets this definition.

4. **LGHP** means a GHP that covers employees of either:

   - A single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or

   - Two or more employers or employee organizations at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year.

5. **Prompt or promptly with regard to liability insurance means payment within 120 days after the earlier of the following:**

   - The date a claim is filed with an insurer or a lien is filed against a potential liability settlement; or

   - The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

With regard to all other primary payers, prompt or promptly means payment within 120 days after receipt of the claim.

6. **Proper claim** means a claim that is filed timely and meets all other claims filing requirements specified by the TPP. (See §3328.1.)
Title: Insurance Standards Bulletin Series--INFORMATION

Subject: Agent Commissions and Application Processing Delays

Markets: Individual and Small Group

I. Purpose

The purpose of this Bulletin is to convey the position of the Health Care Financing Administration on insurance practices that are inconsistent with the guaranteed availability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The specific practices addressed in this Bulletin are:

1. Setting agent commissions for sales to HIPAA-eligible individuals\(^1\) and/or small groups so low that agents are discouraged from marketing policies to, or enrolling, such individuals or groups; and

2. Unreasonably delaying the processing of applications submitted by HIPAA-eligible individuals or small groups.

In addition to the practices discussed in this Bulletin, we have been notified that some issuers may be offering coverage to HIPAA-protected individuals at rates well in excess of the general industry maximum in place before HIPAA of 200 percent of standard risk--in fact, reports indicate premium rates as high as 500 to 600 percent of standard risk. This practice of establishing rates to exclude HIPAA-protected persons is known as "rating up." We have been advised that issuers may be intentionally offering coverage at unaffordable rates, in order to avoid providing coverage to HIPAA-eligible individuals and

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\(^1\) HIPAA contains two definitions of a HIPAA-eligible individual, one in the group market and one in the individual market. (See 45 C.F.R. §144.103, cross-referencing 45 C.F.R. §§146.150(b) (group market definition) and 45 C.F.R. §146.103 (individual market definition).) For purposes of this bulletin, the term "HIPAA-eligible individual" will be used to refer to a HIPAA-eligible individual in the individual market. This will avoid the need to repeat the full phrase "HIPAA-eligible individual in the individual market."

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small groups while appearing to comply with the guaranteed availability provisions of HIPAA. We are continuing to gather information about this problem.

II. Background

Guaranteed availability of health insurance coverage in certain instances is one of the main protections provided under HIPAA. Section 2711 of the Public Health Service Act (PHS Act) requires issuers that sell health insurance coverage in the small group market to accept every small employer that applies for such coverage, even those whose eligible employees include individuals with serious medical problems. Section 2741 of the PHS Act provides that issuers who sell health insurance coverage in the individual market may not decline to offer certain coverage to HIPAA-eligible individuals (unless an approved alternative mechanism applies under State law in which case the rules under such alternative mechanisms would apply). Section 2741 defines a HIPAA-eligible individual as one who meets certain qualifications. Among other things, the individual must have maintained at least 18 months of health insurance coverage; must, most recently, have been covered under a group health plan; and must not have experienced a significant break in coverage, which is defined as a period of at least 63 days without coverage.

Issuers are also subject to certain requirements to furnish information to applicants. In the individual market, the regulation at 45 C.F.R. §148.120(a) requires issuers to act promptly to provide applicants information about available coverage options, including premiums and other costs. In the small group market, 45 C.F.R. §146.160(b)(2) requires any health issuer offering coverage to small groups to include as part of its marketing and solicitation material information about the benefits and premiums available under all health insurance coverage for which the employer is qualified. If premium information is supplied properly, issuers operating in either market should not need to delay the processing of applications in order to finalize price quotes.

HIPAA provides that entities furnishing certain kinds of health insurance coverage, including group coverage, must furnish certificates 1 to individuals whose coverage ends, and at various other times. Individuals may use these certificates to demonstrate that they have maintained health insurance coverage—referred to as "creditable coverage"—which would entitle them to

1 For purposes of this bulletin, the word "certificate" refers to "certificates of creditable coverage" as defined under HIPAA and not the certificates issued under a master group policy. (See 45 C.F.R. §146.115.)
the protections of HIPAA (including status as a HIPAA-eligible individual, as described above). However, the regulation at 45 C.F.R. §148.124(d) permits a HIPAA-eligible individual who for any reason does not have such a certificate to furnish alternative proof of coverage. The regulation specifies, at §148.124(d)(2), what kinds of documentation must be accepted, and how other evidence such as telephone calls and other third party verification must be permitted. In particular, an issuer must treat an individual as having furnished a certificate if he or she attests to the period of creditable coverage, presents relevant corroborating evidence of some creditable coverage during the period, and cooperates with the issuer’s efforts to verify the individual’s coverage.

As stated above, a significant break in coverage terminates an individual’s status as a HIPAA-eligible individual in the individual market. The effect of a significant break in coverage is different in the small group market, where guaranteed availability applies to the group as a whole, providing protection to small employers rather than to individual employees in the group. Section 2701 of the PHS Act \(^3\) protects individual participants in group health plans by limiting the amount of time the plan or issuer may impose a preexisting condition exclusion on a new enrollee. (Under this type of exclusion, the person is covered for all other plan benefits, but has to wait for a certain period of time before benefits are available with respect to the preexisting condition.) HIPAA provides, in general, that a group health plan cannot impose an exclusion period longer than 12 months (or 18 months for late enrollees), and that the exclusion period must be reduced (or eliminated) by the amount of the individual’s prior “creditable coverage,” which can include most kinds of health care coverage. A plan is not required, however, to count as creditable any coverage that is followed by a significant break in coverage - i.e., at least 63 days. If a significant break were to occur due to an issuer’s delay in processing an application for group coverage, then clearly members of that group could be disadvantaged. Although the break would not completely foreclose the members’ obtaining guaranteed coverage—as it can in the individual market—it could delay the start of their coverage, as well as subjecting certain individuals to preexisting condition exclusions.

Enforcement of HIPAA’s standards against issuers of health insurance in both markets is to be performed in the first instance by the States, and by HCFA if a State fails to do so.

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\(^3\) Parallel provisions of HIPAA’s portability provisions under section 2701 of the PHS Act are contained in section 701 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 9801 of the Internal Revenue Code of 1986.
Sections 2722(b) and 2761(b) of the PHS Act provide the major enforcement mechanism with respect to issuers within HCFA's jurisdiction: a civil monetary penalty in the amount of one hundred dollars per violation per day.

III. Agent Commissions

We have become aware that some issuers are attempting to discourage the offering of policies to HIPAA-eligible individuals in the individual market, or to small groups containing high risk individuals, by withholding commissions from agents for sales to such individuals or small groups. Agents have sent us copies of notices from a number of issuers stating they will not pay or will reduce commissions and bonuses for sales to high risk groups and/or HIPAA-eligible individuals. If an issuer pays agents less through all forms of agent compensation (commissions, bonuses, or other rewards) for high risk individuals and groups than it pays for those with better risk profiles, this act constitutes a circumvention of the insurance reform provisions of HIPAA.

Several States have taken action, under their Unfair Trade Practices Acts or their rating authority, to combat the practice of unfairly reducing or eliminating agent commissions. Typically, a State's Unfair Trade Practices Act prohibits any action by an issuer to deflect bad risks away from itself and toward other issuers. Some States that have prior approval of rates have also attacked this practice by declaring that issuers who alter commission structures to deter agents from soliciting or processing applications from HIPAA-protected individuals or groups are using an unapproved rate because the approved rate filing was based on calculations that assumed a certain commission rate. HCFA strongly encourages States to continue to use their authority to take actions against these practices.

While Federal law currently provides no direct equivalent to these State authorities for taking action against such practices, we believe that these and other comparable marketing or distribution practices constitute failure on the part of issuers to offer required coverage to HIPAA-eligible individuals or small employers. The regulation at 45 C.F.R. §146.150(a), provides that issuers in the group market must offer coverage to any small employer and may not decline to offer coverage to eligible individuals under the group plan. With respect to the individual market, (unless an approved alternative mechanism applies under State law in which case the rules under such alternative mechanisms would apply), 45 C.F.R. §148.120 provides that issuers may not decline to offer coverage to HIPAA-eligible individuals (except to limit the types of coverage it offers to its two most
popular or to two representative policies, as permitted by the statute).

The guaranteed issue provisions of the statute generally require that issuers' normal conduits for receiving applications and offering coverage be open to HIPAA-eligible individuals or small employers. Issuers commonly use agents as an important part of their marketing and distribution system, and ordinarily compensate these agents by paying commissions on the coverage they sell. Commission payment is included among the costs used to calculate the premium rate for a given form of coverage. For an issuer to modify the normal operation of its marketing and distribution system so as not to attract its fair share of the high risk individuals and small groups protected by HIPAA does not accord with the intent of the statute to protect these individuals and groups. HCFA will carefully monitor these practices and will take appropriate enforcement action to the extent the practices are found, under the regulations, to constitute a failure to offer coverage.

IV. Application Processing Delays

Another abuse involves issuers' delaying action on applications for coverage submitted by HIPAA-eligible individuals or by small employers, so as to cause the individual or group to incur a significant break in coverage. Such delays are inconsistent with HCFA regulations as described below.

A significant break in coverage has a different effect in the individual and small group markets. Group health plans are not required to take into account coverage from a period prior to a significant break to reduce or eliminate a preexisting condition exclusion, and participants may thus lose benefits they would have been entitled to had there been no delay. In the individual market, a person must (among other requirements) have 18 months of creditable coverage without a significant break to qualify as a HIPAA-eligible individual. A significant break terminates the status of a HIPAA-eligible individual and thus leaves a person without guaranteed access to coverage.

With respect to the group market, we have received reports that issuers held applications for lengthy periods before delivering premium quotes. As mentioned in the Background section above, if issuers comply with the requirement to furnish small employers with marketing information listing the benefits and premiums available under all coverage options, such processing delays should not occur. HCFA will examine these delays carefully to determine whether the marketing information requirements have been violated. HCFA will take appropriate enforcement action to
the extent these delays are found, under the regulations, to constitute a failure to offer coverage.

Similarly, we have been notified that some individual market issuers may be causing HIPAA-eligible individuals to incur significant breaks in coverage by delaying premium quotes and by then quoting premiums that the applicants are not likely to find acceptable. (Under the interim final rule, this kind of delay does not count toward a significant break in the individual market if the HIPAA-eligible individual ultimately purchases the coverage offered. However, if the individual cannot afford the quoted rate, and wishes to look elsewhere, status as a HIPAA-eligible individual may have been forfeited due to the break in coverage.) HCFA will monitor processing delays affecting HIPAA-eligible individuals to determine whether an issuer has violated the requirement to furnish information, including pre-coverage information, promptly. HCFA will take appropriate enforcement action to the extent these delays are found, under the regulations, to constitute a failure to offer coverage.

We have also received reports that some individual market issuers have caused unreasonable delays by demanding that an applicant furnish all supporting documentation to establish status as a HIPAA-eligible individual before an application for coverage will be accepted. In particular, we have heard that some issuers have insisted that an applicant obtain a certificate to prove that he or she has met a particular eligibility requirement, for example, having elected and exhausted continuation coverage, rather than allowing the individual to present other evidence of coverage, or contacting the employer plan from which the applicant last obtained coverage. Cooperation between issuers offering individual coverage and entities that have furnished creditable coverage can permit a HIPAA-eligible individual to move from expiring continuation coverage to a new policy with no break in coverage. HCFA will monitor and take appropriate enforcement action, when issuers are found to have refused applications from HIPAA-eligible individuals based on requirements for documentation that are inconsistent with the regulations.

If you have questions about this Bulletin, call the HIPAA Insurance Reform Help Line at 410-786-1565.

"Continuation coverage" may be either; (1) “COBRA continuation coverage” as mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or (2) similar State mandated continuation coverage.