

JCEB Meeting with HCFA
April 27, 1999
10:00 am–12:00 pm

1. **MSP Rules under *Geissal* Case.** Now that a COBRA beneficiary already on Medicare at the time of a COBRA election is clearly entitled to keep both Medicare and COBRA for the full duration of the COBRA period, several questions arise as to how the Medicare Secondary Payor rules are to be applied:

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

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

b. When the COBRA qualifying event is divorce, assume that the covered employee on whom the ex-spouse's coverage was based before the divorce continues to be employed. While they are married, the spouse's coverage is clearly due to the participant's current employment status, so that if the spouse is on Medicare due to age or disability then Medicare will be secondary. Following the divorce, is it correct that the Medicare-enrolled spouse will have COBRA coverage as a result of the divorce, and not as a result of the employee's continued employment, and that Medicare will become primary for the spouse?

Answer: They need to think further about that one. We discussed a HCFA opinion letter that a JCEB attendee remembered seeing, which applied to the period before the statute was changed to base MSP responsibility on "current employment status," but none of the HCFA representatives remembered seeing it. If a copy can be obtained for HCFA's reference, it will be provided to them.

c. In the case of ESRD, is it correct that the 30-month Medicare secondary period will be applied only once to the individual, regardless of whether it runs before or after the COBRA coverage period? (Presumably, the 30-month MSP period could even occur partially before and partially after the COBRA effective date.)

Answer: In the case of ESRD, the 30-month period works normally for the person and the plan. Note, however, that if the ESRD starts after the person is on Medicare for some other reason, the Medicare entitlement is deemed to continue based on the original purpose, and does not switch to ESRD, so long as that original purpose continues to be applicable (for example, if the Medicare entitlement was due to disability, so long as the person is still disabled).

2. **Cafeteria Plans.** For the last two years we have asked several questions about the interaction between the Medicare Secondary Payor laws and Cafeteria Plans under Section 125 of the Internal Revenue Code. Summaries of those questions and our understanding of your previous answers are listed below. Have your answers changed in any way?

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.

b. 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?

c. 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?

d. What if its choice of non-taxable benefits not covered by Section 125?

e. 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.

Previously, HCFA representatives indicated that people should not be penalized for participating in a cafeteria plan that qualifies under Section 125, and that whatever is permissible under 125 should be permissible under MSP. In September of 1997, HCFA released a letter taking this position in writing (a copy of which is attached), and we were told that you hoped to eventually propose regulations to that effect. Since then, some of us have heard rumors that current HCFA officials are not necessarily in agreement with the explanation in that letter.

In the case of a plan offering only a choice of non-taxable benefits, which is not subject to Section 125 of the Internal Revenue Code because that section is designed to avoid the "constructive receipt" that would otherwise occur where one of the choices might be taxable, HCFA officials felt that there might be a problem

if a Medicare-eligible person was allowed to choose something else instead of the employer's health plan, even though everybody else gets the same choice.

Answer: Their OIG has some second thoughts about the letter, so they are not at all sure that the letter indicates what will be their ultimate position. They'll have to consider it.

Individual Policies

3. Has there been any progress in limiting the excessive premiums that some insurers were charging HIPAA-eligible individuals, or in limiting the enrollment delays that can cause a 63-day break in coverage if the policy is not ultimately issued, as discussed in your March 1998 bulletin (a copy of which is attached)?

Answer: Some states have been taking action. Where HCFA is in charge of enforcement, they are gearing up to take action. They are getting ready to issue an enforcement policy statement and are training people. Milliman and Robertson, under a contract with HCFA, is doing actuarial review and is looking at policies that have been submitted, so that HCFA can be informed as to what is an unreasonable premium.

4. 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: Last year's list is still current except that Michigan adopted legislation. Arizona, Colorado, Delaware, Hawaii, Maryland, North Carolina, Tennessee, Massachusetts, and Missouri and Rhode Island and California (with HCFA enforcing the last three) do not have alternative mechanisms. In Massachusetts, there is some question since the mechanism is pre-HIPAA. The list from last year of alternative mechanisms is pretty current. Linda Sizelove, at 410-786-3255, has an updated list.

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

Answer: HCFA's resources are not unlimited, but they are improved and they do plan to enforce the rules when they have clear evidence of non-compliance.

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

Answer: Yes, if they had enough documented evidence. But most states cooperate when approached by HCFA.

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

Answer: Some insurers have withdrawn, but there has been no mass exodus. Some of those who withdrew have said they were going to do it anyway.

Small Business Policies

8. Has there been any progress in limiting the reduced commission and other practices as discussed in your March 1998 bulletin (a copy of which is attached)?

Answer: Some states have been taking action.

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

Answer: There seem to be several insurers who have withdrawn. Also, once they couldn't underwrite for late enrollment many insurers have decided not to offer any late enrollment. They are studying the question to report to the President, and expect to have a hearing. Not offering late enrollment is legal now, but they are considering asking the President to suggest legislation requiring late enrollment at least once a year, particularly if the choice was to be in the spouse's plan and the benefits under the spouse's plan have changed so that now the person would rather be in his own employer's plan.

10. **Privacy Regulations.** If the Congress fails to enact privacy legislation, HHS must issue regulations on privacy. Legislation now seems unlikely. Is HHS gearing up to issue such regulations? If HHS has to issue privacy regulation, are they apt to be of the NAIC-type, or will some other model be used?

Answer: Several privacy bills are in the works, including one of the Secretary. HCFA has a group in place getting ready to issue regulations by February of 2000, as required by the law. They are not waiting until August to get started even though Congress has until August to enact the legislation.

11. **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: They have a list on the web page, but it's not complete. About 600 plans have submitted elections. Some such plans have been confused in that they didn't understand that they had to resubmit annually. It has been all over the map as to what they have opted out for — some just on the discrimination rules, some just

Mothers and Newborns, etc. Texas seems to have the highest number of opting out plans, possibly because Texas has lots of different entities operating separate plans, as opposed to some other states where a single plan may cover the schools in a large geographical area, for example.

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

Answer: The Individual Identifier is on hold until emergency privacy protections can be put in place. On the employer identifier, they have proposed using the IRS tax ID number, and that is pretty non-controversial.

On the provider identifier, which was proposed to be a specially designed 8-digit unique identifier for each provider, created and assigned randomly, it is controversial since many plans already have identifiers for each provider and those numbers may involve separate numbers for each address of a multi-facility provider. This can be important because different geographic areas may result in different payments, and thus different numbers are important. Also, some providers have different Medicare carriers or intermediaries, and thus have different numbers. These business needs must be addressed.

Nothing is out on health plans, but they hope to have a proposal out soon (this Spring). Again, there are business needs, and they are struggling with whether it should be the particular ERISA plan, the third party administrator, something in between, or whatever.

13. **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: Nobody familiar with this issue was able to attend.

14. **Self-Insured Plans with Stop-Loss Coverage.** Clearly, self-insured plans must comply with HIPAA, just as insured plans must do. In the case of an insured plan, however, the insurer is also specifically required to comply. The following questions were asked last year, but HCFA declined to answer following its discussions with the Department of Labor, which was involved in pending litigation and/or enforcement efforts. We'd appreciate any update that you can give us as to these questions:

a. In the case of a self-insured plan with stop-loss coverage, which is typically set up so that the employer funds whatever benefits the employee premiums don't cover, must the stop-loss insurers comply with HIPAA?

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?

15. 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.
16. 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?
17. 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?
18. Employers are no longer permitted to deny admission to a plan based on health status factors, but employers will be placed in a tremendous bind if the stop-loss carriers can "red-line" the high-cost individuals. Will stop-loss carriers be allowed to do this?

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, and it cannot refuse to cover the costs of an individual participant or beneficiary based on that person's individual medical status factors.

Answer: They can't answer this yet. Once the non-discrimination regulations are issued (hopefully this summer), they hope to address this type of issue.

Medicare Secondary Payor

19. Assume that an individual who is past age 65 wished to continue working, but only on a part time basis, and that part time employees of that company are not entitled to health benefits. Can the employer pay the premiums for that individual for his (a) Medicare coverage or (b) Medigap policy?

Proposed Answer: Any such payment to a Medigap policy would be because of his current employment status, which would appear to violate the Medicare as Secondary Payer Rules. On the other hand, the Medicare coverage is provided by the government, so that allows for a different result.

Answer: The employer's purchase of a Medigap policy would likely convert the policy to a second employer-sponsored group health plan. It might even take it out of needing to meet the normal requirements for a Medigap policy, since one of the definitions of a Medigap policy is that it is not a group health plan.

On paying Medicare Part B premiums, one representative expressed concern that this might present the same problem as paying for a Medigap policy, since it involves an employer program that takes Medicare into account.

20. We understand that it is HCFA's position that a plan covering transplants must cover kidney transplants, and that if there is a cap on transplant coverage the kidney transplant cap can be no lower than the highest cap on any other type of transplant.

a. Is this a correct statement of HCFA's position?

Answer: They don't recall saying it before, and would like to see a copy of any letter that might have said it. But they'd need to think about it. By setting a cap so low that it effectively made HCFA the primary payor for kidney transplants, might be argued to be a violation, but they'd want to think about it.

b. Suppose the cap for a particular plan is expressed as a dollar amount, and the dollar amount for each type of transplant is designed to be high enough to cover one and only one of each of such transplants for a covered individual. Suppose also that kidney transplants are considerably less expensive than some other transplants covered by the plan. Would the plan have to assign the kidney transplant the same dollar cap as the transplant with the highest dollar cap, even though that would allow a covered person to receive more than one kidney transplant, or is it sufficient for the plan to have a limit high enough to cover one kidney transplant so long as that is the maximum number of other types of transplants that can be covered within the plan's other transplant caps?

Answer: They don't have an answer.

21. **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 C or also the patient C 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's office is in charge of this, and nobody was in attendance from that office. They'll try to get us names of people to approach in future years.