Joint Committee on Employee Benefits Q&A
with the Centers for Medicare and Medicaid Services
May 8, 2002

The following questions and answers are based on informal discussions between private sector representatives of the JCEB and Health and Human Services Department and Health Care Finance Agency officials. The questions were submitted by ABA members, and the responses were given at a meeting of JCEB and government representatives. The responses reflect the unofficial, individual views of the government participants as of the time of the discussion, and do not necessarily represent agency policy. This report on the discussions was prepared by designated JCEB representatives, based on the notes and recollections of the JCEB representatives at the meeting (except that those answers designated as "Written Answers Provided" were provided by one or more agency officials), and this compilation has not been reviewed by HHS or HCFA/CMS personnel. The questions were submitted in advance to the agency, and it was understood that this report would be made available to the public.

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1. **Cafeteria Plans.** For the last several years we have asked questions about the interaction between the Medicare Secondary Payor laws and Cafeteria Plans under Section 125 of the Internal Revenue Code. By 1998, we were pleased with the workability of the answers. The answers in 1999 appeared to differ substantially from prior year's answers, and in 2000 and 2001 we were told that guidance was near completion and that officials preferred not to discuss the issue further until the guidance was released. We have seen no guidance, and would like to know CMS' current position on these issues.

    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?

            Proposed Answer: No. Employees on Medicare may be offered the same options as any other employee to get cash instead of the employer's health plan pursuant to a cafeteria plan qualified under Section 125 of the Internal Revenue Code.

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

Proposed Answer: Again, whatever the benefits and limitations are for those under age 65 should be the same for those over 65.

iii. What if it is a choice among non-taxable benefits not covered by Section 125?

Proposed Answer: Non-125 options are fully subject to the literal application of MSP. Section 125 of the Code was specifically enacted by Congress as a benefit intended to be made available to employees. Anything legal under that provision should be legal under MSP. However, whatever results follow from more general provisions of the tax code can more easily be presumed to be overridden by the specific MSP rules enacted by Congress.

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.

Proposed Answer #1: Again, if it's permitted under Section 125 of the Code, it will not be subject to MSP. Therefore, health flexible spending accounts authorized under Section 125 of the Code will not be expected to be primary to Medicare.

Proposed Answer #2: Health flexible spending accounts that are exempt from HIPAA — those which provide maximum benefits no greater than twice the employee contribution or $500 more than the employee contribution, and which are offered to individuals who are already offered coverage by another true

major medical plan of an employer — will not be subject to MSP.

Actual Answer: Anything permissible under Section 125 of the Internal Revenue Code CAN be offered to Medicare people as long as it is also offered to everyone else. Medicare would be secondary to the extent of medicare-eligible expenses. They are not prepared to endorse above issues that are not permitted under Section 125 of the Code. See attached letter for more detail.

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2. **MSP Data Match Program Electronic Information Exchange Alternative.** How is this new program working out?

Actual Answer: The Data Match electronic information exchange is working extremely well. An employer who participates is relieved of the annual requirement otherwise applicable, to fill out a data match questionnaire. Employers are seeing a 4-1 return on their investment, because this way they know who the Medicare beneficiaries are for whom Medicare is primary. They require a certain minimum amount of data in a certain prescribed form. The largest operational impediment has been finding where the data is stored in the company. They aren't always able to negotiate centralized data on claims for past amounts.

They have form agreements, which can be obtained from John Albert. They have incorporated privacy provisions.

See pre-prepared answer, attached.

3. **MSP – ESRD.** Does the MSP statute require coverage of dialysis?

Proposed Answer: No, so long as the plan does not cover dialysis for conditions other than ESRD. If it does, dialysis for ESRD must be included at at least the same benefit level as the other conditions.

Actual Answer: The proposed answer is correct. They have not found a basis in the statute for any other result, even though the vast majority of the people requiring dialysis are ESRD patients.

4. **MSP – ESRD.** Last year you gave us a copy of a 1994 letter explaining that separate caps on ESRD or kidney transplants must be computed actuarially, so as to provide the same level of care as other diseases, in order for the differentials to be permissible under the MSP rules. (A copy of that letter is attached to last year's answers, which are in turn attached to this year's questions.) How exact must these actuarial calculations be? For example, is it enough for the plan administrator to make a good faith determination of

reasonable treatment costs? Or is the actual involvement of an actuary, with true actuarial projections, necessary? If the latter, how would one determine the proper actuarial assumptions?

Proposed Answer: Any reasonable good faith determination is sufficient.

Actual Answer: An actuarial OR EMPIRICALLY DERIVED determination is permissible. They do not approve of the term "reasonable good faith," however, because it is vague.

5. **Medicare Choice Plus HMOs under Medicare Secondary Plans.** Is it possible for employees on Medicare to be enrolled in a Medicare Choice Plus HMO where the employer is still primary? If so, how does this work? Or, is Choice Plus enrollment limited to those individuals for whom Medicare has become primary?

Actual Answer: Any medicare eligible beneficiary can join a Medicare Choice Plus Plan. If CMS knows it is secondary, based on the individual being working aged, having ESRD, etc., CMS adjusts the rate it pays to the Medicare Choice Plus Plan.

If the Medicare Choice Plus Plan covers an individual who is also receiving workers' compensation, tortfeasor insurance, or similar sources, CMS does not make any official adjustments and the plan can keep whatever it receives for the beneficiary's care. However, the amounts the programs are entitled to recover from CMS will, over time, count against the program whether or not the program is successful in its recovery effort.

6. **HIPAA – Retiree Medical Plans.**

a. Do the HIPAA requirements relating to portability, access and renewability under apply to a group health plan that only covers retirees?

Proposed Answer: I.R.C. Section 9831(a)(2) and ERISA Section 705(a) (albeit under the heading "general exception for certain small group health plans") provide that the HIPAA requirements do not apply to a group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees. Thus, a stand-alone retiree medical plan that covers no current employees is exempt from the HIPAA requirements, regardless of the number of retirees covered thereunder.

Actual Answer: The proposed answer is correct.

b. If the proposed answer is correct, does the retiree plan lose its exemption from HIPAA if the employer allows the retirees to return to work for the employer at a level less than would qualify them for the employer's regular health plan? For example, if the plan requires work at a 25-hours-per-week rate, and the retiree is limited to 10 hours per week. Under MSP rules, the retiree plan would remain primary for that individual. Is the result the same under HIPAA?

Proposed Answer #1: No, the result is the same as under MSP, and the plan does not lose its exemption so long as the work is less than what would qualify the individual for regular coverage under the employer's plan.

Proposed Answer #2: The rules are different under HIPAA than under MSP. Yes, the retiree plan would lose its exemption if two or more retirees covered by the plan returned to any kind of employment status with the sponsoring employer.

Actual Answer: Number two is the correct answer – the statute gives them no flexibility. It is, however, measured on the first day of the plan year.

c. If a group health plan covers both current employees and retirees, but dependent coverage for retirees is limited to a retiree's dependents at the time of his or her retirement (i.e., any NEW dependent is ineligible) while dependent coverage for current employees includes the full ability to add new dependents, must the plan permit enrollment (under HIPAA's Special Enrollment Rights rules) by a dependent acquired by a retiree after retirement?

Proposed Answer: I.R.C. Section 9801(f)(2)(A)(i) and ERISA Section 701(f)(2)(A)(i) apply a special enrollment period in the event of a new dependent if the group health plan otherwise provides dependent coverage. Where a different class of eligible dependents is provided for covered current employees than is provided for covered retirees, these statutory provisions, and the related interim regulations, only require coverage of a new dependent if that individual qualifies as a "dependent" under the plan terms as they apply to retirees. Thus, retiree plans CAN freeze the eligibility of retirees to those dependents whom the retiree has at the time of entry into the plan.

Actual Answer: Under 45 CFR §146.117b5, if the retiree has been on the plan since first eligible, special enrollment would be required. However, if the retiree fails to enroll, a later marriage does not give either the retiree or the new spouse any kind of special enrollment right.

*7. **HIPAA – Small Business Rules.**

In the past, some small businesses, particularly those in industries where there is high turnover, such as restaurants and retail, used a collection of individual health insurance policies in lieu of a true group plan. Premiums were paid by the employees on a payroll deduction basis, rather than by the employer as group health insurance coverage for employees. The reason for doing this was that certain industries with low-income employees find it difficult to obtain the 75% participation required by many insurers for a group plan due to the high turnover rate and low or nonexistent employer financial contribution, and could avoid the insurer's 75% requirement by purchasing of a series of individual policies for those employees who wished to pay the premiums. Many states, along with CMS and DOL, have ruled that any health insurance benefits where the employer "sponsors" the plan, even by merely payroll deducting the cost, are considered "employer sponsored" and as such are subject to small employer rules, including those prescribed by HIPAA, and also to HIPAA's nondiscrimination rules. The individual policies that were sold in the past under this arrangement were not intended to function under most employee benefit regulations, and insurers are unwilling to issue the policies if they will be subject to HIPAA's requirements. Therefore, payroll deduction of individual policies is no longer available in many markets as a health insurance option for small groups. There is great support for employer sponsored plans, but there are situations where the best solution may be individual policies offered through the place of employment.

Given the concern over the uninsured, can payroll deduction of individual policies be an exception to HIPAA requirements if it is done within specific guidelines?

Proposed Answer #1: Where the employer acts only as a non-contributing sponsor, by allowing voluntary plans to be presented to the employees, and the employer merely facilitates the employees' payment of premiums by authorized payroll-deductions, such voluntary and non-contributory plans will not be subjected to HIPAA [nor to COBRA, ERISA or other mandatory federal regulations] as would otherwise be applicable for employer-sponsored contributory plans.

Proposed Answer #2: The current statutory provisions do not permit the agencies to exempt employers and insurers from HIPAA's requirements merely because the health insurance program consists of individual policies.

Actual Answer: A Group Health Plan is "established or maintained" by the employer or the employee organization. We were given a November 2000 notice, which is attached, discussing two scenarios that they would consider not to be within the spirit of the law.

8. **MSP – Data Collection.**

HMA issued an alert saying that CMS will be collecting the Medicare Secondary Payer information from hospitals every 90 days, instead of the prior practice of doing so every 30 days for repeat outpatient services and every 60 days for laboratory work. What implications this will have on enforcement for MSP? It is solely a paperwork reduction issue?

Actual Answer: CMS does not collect MSP information from hospitals. Hospitals ask their patients if they have other insurance that would be primary to Medicare. CMS gives the hospitals a list of questions which, if all are asked, should make the hospitals feel comfortable that they have made a full inquiry. Until recently, CMS policy was that the questions had to be asked every time there was a bill. CMS has now relaxed the standard so that the questions need be asked no more frequently than every 30 days for services of a recurring nature, and every 60 days for lab work. Now there is a change to even that policy, which is to require the hospital to ask the questions a minimum of once every 90 days – at the first encounter, and then no later than 90 days later if there are multiple encounters.

The implications of enforcement for the MSP rules are that CMS will audit hospitals to see if the hospitals asked the appropriate questions and if the billing was based on the answers received. If the hospital has complied, the hospital will have met CMS's expectations. Under the more relaxed policy, CMS will continue to audit hospitals, but the hospitals will not be liable solely for failure to ask the questions no more frequently than every 90 days. However, if it turns out that there is other coverage that the hospital did not discover, the hospital will still be expected to return any over-billing, even though it will not be liable for penalties for failure to discover the other coverage.

In one sense, this new pronouncement has no impact on enforcement, and is purely a CMS paperwork reduction effort. The hospital takes advantage of the relaxed requirement at its own

risk, and will still be fully liable, including penalties, for any incorrect billing. But it should help the hospital administratively.

9. **EDI Compliance Plans.**

The Health Insurance Portability and Accountability Act (HIPAA) requires covered entities to conduct health care transactions electronically by October 16, 2002, according to HIPAA's electronic data interchange (EDI) and medical data code set rules. The Administrative Simplification Compliance Act (ASCA), signed on December 27, 2001, extended the deadline for complying with the EDI and medical data code set requirements of HIPAA for one year, to October 16, 2003, for all plans if certain conditions are met. The Centers for Medicare and Medicaid Services (CMS) recently published a Model Compliance Plan that can be used to request the one-year extension available under the ASCA. Guidance issued by CMS in March 2002 states as follows:

> If you are filing for multiple related covered entities that are operating under a single implementation plan, list their names, tax identification numbers and Medicare identification numbers. Compliance plans for unrelated multiple covered entities or for related covered entities that are not included under the same implementation plan must be filed separately. Are you filing for a health plan, health care clearinghouse or other health care organization that has multiple components? If they are operating under the same implementation plan, then you can file one compliance plan on their behalf. If not, then you must file separate compliance plans for each entity. See also (5) "Authorized Person" for more information. http://www.cms.hhs.gov/hipaa/hipaa2/TCSFormInstructions.asp?

a. May a health insurance issuer or HMO file a Compliance Plan on behalf of its insured employer-sponsored group health plans?

Proposed Answer: Yes. A health insurance issuer or HMO is a covered entity and has its own obligation to file a Compliance Plan. An employer-sponsored group health plan that is insured by an insurer or HMO could be considered a related covered entity operating under a single implementation plan and therefore the filing could be for both entities.

Actual Answer: The Compliance Plan must be filed by an authorized person. If there is a question, CMS needs an authorized contact. The authorized person could be anyone, including a third party administrator or contractor. If a third party administrator files the Compliance Plan on behalf of a group health plan, it should communicate with the plan sponsor to assure that it has authorization to do so. CMS is

not tracking who files the Compliance Plans, and the system does not record the electronic address of the filer.

The most important information CMS is looking for is the name of the entity, name of the authorized person, and tax identification number. The National Committee on Vital and Health Statistics (NCVHS) will review the other information for statistical research purposes.

CMS will be issuing two changes to the Compliance Plan model:

1. CMS will provide a secured server option for filing the Compliance Plan.

2. CMS will issue modifications that would allow filing for multiple covered entities under the same compliance implementation plan. The authorized filing entity would fill out one form, but be able to repeat Questions 1-4 for all entities that it is filing on behalf of. An electronic response will provide a separate filing verification number for each covered entity.

CMS noted that additional information is available in two places. First, information regarding HIPAA can be found at http://www.cms.hhs.gov/hipaa. Second, questions may be submitted to them at http://aspe.os.dhhs.gov/admnsimp/bannertx.htm, and answers to frequently asked questions are also available at that site.

b. May a health insurance issuer or third party administrator file a Compliance Plan on behalf of a self-insured employer-sponsored group health plan for which it performs administrative services only?

Proposed Answer: Yes. A health insurance issuer or third party administrator that provides administrative services only may file a Compliance Plan on behalf of its self-insured clients that sponsor group health plans.

Actual Answer: See response to question 9.a., above.

c. An employer-sponsored group health plan is self-insured and uses several vendors to provide administrative services, including a third party administrator, pharmacy benefits manager, and behavioral health managed care organization. Each entity

has a different HIPAA implementation plan. Who is responsible for filing the Compliance Plan and how should it be filed?

Proposed Answer: Each administrative services provider should be able to file a Compliance Plan on behalf of its clients, as they are operating under a single compliance plan. Therefore, the TPA, PBM, and behavioral health MCO should each be able to file a Compliance Plan on behalf of their client self-insured group health plans. In the alternative, a self-insured group health plan should be able to file a Compliance Plan using the information provided by its service providers. If there are conflicting dates for testing, the group health plan should be able to complete the Compliance Plan by referring to the latest testing date for its service providers.

Actual Answer: CMS indicated that the covered entity filing the Compliance Plan should choose how to file its plan when it has multiple vendors. CMS indicated that testing must begin no later than April 2003.

d. Supplemental Comments. The following comments were made during discussion in response to questions asked orally at the meeting:

i. They are not tracking who is filing the compliance plans. Rather, the plan must be filed by an authorized person. Apparently, some companies are making a business of filing these extensions, which is not quite what they had in mind, but an authorized person can file them and be on the form as the authorized person. No contract is necessary, although a contract would be permissible. The purpose of the form is really just to make people think about what they need to be doing to become HIPAA-compliant.

ii. TPAs can do the compliance plans on behalf of their plans, but should tell each plan or employer that it has done so. The Administrative Simplification items can be sent in on an e-mail address – ASKHIPAA. The most frequently asked questions will go on their web site, at www.cms.hhs.gov/HIPAA.

iii. It does not matter to them who files the plan, but they should all be filed.