

AMERICAN BAR ASSOCIATION

Technical Session Between the Centers for Medicare and Medicaid Services and the Joint Committee on Employee Benefits

May 16, 2005

The following notes are based upon the personal comments of the various individuals from the Centers for Medicare and Medicaid Services who attended a meeting with the representatives of the various sections comprising the Joint Committee on Employee Benefits from the American Bar Association on May 16, 2005. The comments were made by these individuals in their individual capacity and not as representatives of the Centers for Medicare and Medicaid Services. The comments do not represent the position of the Centers for Medicare and Medicaid Services or of any other government agency or office. None of the comments should be considered official guidance or the position of any agency.

This document has been prepared by private sector members of the American Bar Association's Joint Committee on Employee Benefits who were present at the meeting and reflects their description of the answers to the questions that were discussed at the meeting. This document has not been reviewed or cleared by the government individuals involved in the meeting.

1. MMA Section 301(b).

Question: Section 301(b) of the Medicare Modernization Act (MMA) amends the Medicare Secondary Payer (MSP) provisions to provide that CMS can collect funds from an employer, even in a fully insured plan, for any Medicare overpayments due to Medicare's paying primary when the employer's plan should have been primary. Section 301(c) provides that this change is effective as if included in the enactment of Section 953 of the Omnibus Reconciliation Act of 1980. Is CMS interpreting this amendment as if it applies to claims incurred prior to the passage of MMA, or only for those claims incurred on or after its passage.

Proposed Answer: On its face, the amendment appears to apply retroactively to 1980. However, if employers with insured plans were not liable prior to the passage of MMA, it is questionable constitutionally whether this amendment can apply to claims incurred prior to MMA. Therefore, the amendments made by Section 301(b) of MMA should only be applied to claims incurred on or after the passage of MMA.

Answer: The amendment made by Section 301(b) of the MMA is not a new law, it is merely a clarification of existing law. CMS has always had the authority to make the aforementioned collections since 1980, and therefore the clarification will be applied from 1980 as well.

There is no official instruction in the field to specifically enforce the clarification or to go back and try to recover previously unrecovered amounts. Investigators will apply the clarification if the situation warrants, subject to the general statute of limitations rules that apply to collections under the MSP rules.

2. Security Rule and Electronic Transactions Guidance.

Question: CMS has continued to update the frequently asked questions on the HIPAA Electronic Transactions and Security Rules, which has been very helpful. (ABA members should be aware that the CMS frequently asked questions and answers are available at <http://questions.cms.hhs.gov/>.) Are there any plans, however, to issue any more formal guidance on the HIPAA Electronic Transactions or Security Rules?

Answer: Currently, the CMS frequently asked questions will be the main vehicle for distributing additional security rule and electronic transactions rule guidance. No formal guidance is contemplated at this point.

3. Security Incident Reporting.

Question: Nothing in the Security Rule itself or the preamble provides how a business associate is to report security incidents pursuant to Section 164.314(a)(2)(i)(C) of the Security Rules. Last year we inquired regarding the format and timing of these reports,

and you indicated, unofficially, that covered entities and business associates are free to establish the format and timing of these reports as long as the protocols are reasonable and appropriate given the circumstances.

Since last year, large health plans were required to comply with the business associate agreement provisions of Section 164.314 of the Security Rule. As part of this process, many large health plans have had difficulty in obtaining any information at all from their business associates regarding how and when security incidents will be reported. It would be extremely helpful to health plans and other covered entities, if CMS issued guidance on how and when security incidents must be reported by business associates. Do you anticipate issuing guidance regarding security incident reporting, and if so, what format do you anticipate this guidance taking?

Answer: This question was answered by various frequently asked questions that were recently issued. Based upon those frequently asked questions, JCEB members asked additional follow-up questions as follows:

Follow-Up Question #1: The FAQs refer to amending the business associate agreement and the health plan document to include the security incident reporting procedures that apply to the business associate and health plan sponsor. Will there be a violation of the Security Rules, if such amendments are not made?

Follow-Up Answer #1: Yes. There would be a technical violation.

Follow-Up Question #2: The FAQ regarding covered entities includes more examples of security incident reporting procedures than the other FAQs. Is there a reason that those additional examples are not included in the FAQ that applies to business associate agreements?

Follow-Up Answer #2: No. The examples in the covered entity FAQ all apply to business associate agreements as well.

Follow-Up Question #3: How is identity theft enforced under the HIPAA Security Rules?

Follow-Up Answer #3: CMS will forward complaints to the Department of Justice, if the identity theft was criminal. If a complaint relates to a non-HIPAA covered entity, CMS may refer such complaint to another agency that has jurisdiction.

4. Insured Group Health Plans.

Question: How does the Security Rule apply to a group health plan, where the benefits are provided through an insurance contract or HMO and where the health plan's sponsor does not receive any ePHI from the insurer or HMO other than enrollment information and/or pursuant to an individual's authorization?

Proposed Answer: Section 164.530(k) of the Privacy Rule provides that a group health plan is not subject to most of the Privacy Rule requirements to the extent that the group health plan provides benefits through an insurance contract or an HMO, and the plan does not create or receive PHI except for summary health information or enrollment information. There is no similar express exception for purposes of the Security Rule. However, Section 164.314(b)(1) of the Security Rule does provide that the group health plan's plan documents do not need to be amended if the only ePHI that the plan sponsor receives is enrollment information or pursuant to an individual's authorization.

Despite the absence of an express exception, the Security Rules only apply to the extent that the plan creates or maintains ePHI. Therefore, if benefits are provided through an insurer or HMO and the only ePHI received or maintained by the employer on behalf of the plan is enrollment information or pursuant to an individual authorization, the Security Rules do not apply to the group health plan.

Answer: The employer must go through the risk analysis required by the HIPAA security rules to determine if any of their computer systems contain ePHI. Assuming no ePHI was discovered during the analysis, based on the flexible standards of the HIPAA security rules there would not be much more for the employer to do.

5. **Self-Insured Health Plan with no ePHI.**

Question: What are the Security Rule compliance duties, for a self-insured health plan that does not receive any ePHI from its business associates?

Proposed Answer: If a self-insured health plan does not receive or maintain any ePHI (other than enrollment information or pursuant to an individual authorization), and all the plan's ePHI is maintained by the plan's business associates, the employer on behalf of the plan should not have to complete all of the Security Rule compliance steps. However, in this situation, the following compliance steps appear to be relevant in this circumstance.

First, the plan should appoint a Security Official as required under Security Rule Section 164.308(a)(2). Even though the plan is not maintaining any ePHI, you need someone to document that fact and the Security Official is the most logical person to do that.

Second, the Security Official should conduct a review and survey of the employer's information systems to make certain that it is not maintaining any ePHI on behalf of the plan. This survey should be documented in writing. Once the survey is complete and documented and the Security Official has confirmed that no ePHI is maintained, then the employer on behalf of the plan should not need to perform a risk analysis.

Third, while the plan should not need to adopt the policies and procedures listed in the Security Rule, it should adopt a policy that requires the Security Official to periodically

re-evaluate whether the plan is maintaining ePHI. See, Security Rule Section 164.308(a)(8).

Fourth, the business associate agreements must also be amended as required by the Security Rule.

Answer: The employer must go through the risk analysis required by the HIPAA security rules to determine if any of their computer systems contain ePHI. Assuming no ePHI was discovered during the analysis, based on the flexible standards of the HIPAA security rules there would not be much more for the employer to do, other than business associate agreement amendments and the health plan amendment if required.

It is important to note the continuing confusion over enrollment information. Enrollment information is PHI and ePHI (if in electronic form) when it is held by the plan, but it is not PHI or ePHI when the enrollment information is created, maintained and transmitted by the employer.

CMS will look to the health plan document to determine what is employer information and what is plan information or PHI. Therefore, a plan in its health plan documents should define the line between employer information and plan information. CMS will consider issuing additional FAQs on this topic.

6. Future Guidance.

Question: Are there any issues regarding the Electronic Transaction Rules or the Security Rules concerning health plans that CMS is currently discussing or evaluating where input from members of the public would be of assistance?

Answer: CMS is very active in soliciting input from interest groups when it determines that it needs additional input. Currently, there are no specific issues for which CMS needs public input.

7. MSP Rules for HSAs.

Question: MMA, enacted in December of 2003, creates “Health Savings Accounts,” or “HSAs.” These may be offered under a 125-qualified cafeteria plan, but also may be offered separately. Indeed, an employer may offer only the “High Deductible Health Plan,” or “HDHP,” and leave it up to the individual to arrange for his or her own HSA.

(a) Will HSAs offered pursuant to a cafeteria plan be exempt from the MSP rules pursuant to your May 29, 2002 letter regarding cafeteria plans?

Proposed Answer: Yes.

- (b) Will HSAs offered by an employer outside of any cafeteria plan be exempt from the MSP rules?

Proposed Answer #1: Yes, payments made from an employer-sponsored HSA will be exempt from the MSP rules, even if they are offered outside of any cafeteria plan.

Proposed Answer #2: HSA accounts that 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 covered by an HDHP will be exempt from MSP. (Based upon the exemption from HIPAA for health FSAs. See, Treas. Reg. 54.9831-1(c)(3)(v).)

- (c) Will HSAs established by individuals for themselves or their family members be required to pay primary to Medicare? Is the answer different depending on whether they are funded entirely by the individuals and/or family members or whether an employer contributes to the HSAs?

Proposed Answer: No, individually established HSAs will not be subject to the MSP rules whether or not they receive employer contributions.

Answer: CMS indicated that it needs to examine the issues in more detail, and requested guidance on the operational requirements of HSAs.

In addition, CMS plans to issue around July 1, 2005 coordination of benefits requirements for MSAs and HSAs for purposes of Medicare Part D. This will not be published as a regulation, but rather as regular guidance.

CMS also indicated that HSAs will also be addressed in the proposed regulations for the HIPAA national health plan identifier. The proposed regulations are scheduled to be published by the end of 2005.

8. MSP Rules for HRAs.

Question: IRS Notice 2002-45 provides guidance regarding Health Reimbursement Arrangements or “HRAs.” These accounts will be entirely funded by employers, to reimburse employees and their dependents for medical expenses not otherwise covered by a regular group health plan. Because there is no opportunity for the individuals to receive the funds for anything other than qualifying medical expenses under Code Section 213(d), Section 125 is not needed in order to make the HRA reimbursements free from tax. Therefore, they fall outside the exemption articulated in your May 29, 2002 letter regarding Section 125 cafeteria plans. However, administering these generally small accounts will be much more complicated if the accounts must be primary to Medicare for the employees receiving Medicare benefits (or those with family members receiving Medicare benefits). Is it CMS’ position that HRA accounts must be exhausted

before Medicare is required to pay any amounts not otherwise covered by the regular group health plan covering the employee or family member?

Proposed Answer #1: No, payments made to employees or their family members pursuant to an HRA that complies with the requirements of IRS Notice 2002-45 will not be required to be primary to Medicare.

Proposed Answer #2: HRA accounts that 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 regular major medical plan of an employer will be exempt from MSP. (Based upon the exemption from HIPAA for health FSAs. See, Treas. Reg. 54.9831-1(c)(3)(v).)

Answer: CMS indicated that it needs to examine the issues in more detail, and requested guidance on the operational requirements of HRAs.

9. Part D – Employer Subsidies.

Question: Although state and local employers are eligible to apply for the employer subsidy under Part D, the subsidy is calculated based on the number of employees eligible for Part D. Eligibility for Part D is based on eligibility for Medicare generally. If an employee is eligible for Medicare because he or she is covered by a state retirement system that does not participate in Social Security, is the state eligible to claim a subsidy for its retiree prescription drug program?

Answer: CMS is not planning any additional guidance on this issue. The individual must be entitled to or enrolled in either Medicare Part A or Part B. If the individual meets that criteria, then the state and local government can apply for and receive the subsidy.

10. Part D – Creditable Coverage Notification.

Question #1: Employers who do not have retiree medical benefits appear to have a notice requirement, but there does not appear to be any penalty imposed upon the employer for not issuing the notice.

Answer #1: CMS will be shortly issuing rules on the notice requirement. In general, an employer must give the notice if it has an employee who is Medicare eligible. There is no penalty for not giving the notice, but it protects the beneficiary from having to prove to Medicare that he/she had creditable coverage.

Question #2: Will the guidance on the notice rules incorporate a simple design which will allow small health plans to not have to determine actual experience?

Answer #2: Yes.

Question #3: Can an insurance company provide the notice for fully insured health plans?

Answer #3: Yes. The notice may also be included in the insurance certificates or booklets.

Question #4: In determining whether an employer's prescription drug coverage is actuarially equivalent to the Part D benefit, what drugs can be included?

Answer #4: The employer can only include drugs that are covered by Part D in determining actuarial equivalence. Foreign drugs, over the counter drugs and experimental drugs cannot be included in the calculation.

11. Part D – Eligibility.

Question: Can an employer exclude individuals who signed up for Part D from the prescription drug portion of an employer's retiree medical plan?

Answer: Part D does not prohibit the exclusion, but other laws may prohibit it.