

Human Resources Bulletin



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Does Your Company Have Insurance Coverage? If Yes, The Medicare Secondary Payer Reporting Rules May Apply.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added a new provision to the Medicare Secondary Payer rules requiring mandatory reporting requirements for:

- group health plans (GHP)
- liability insurance (including self-insurance)
- no-fault insurance
- workers' compensation (non-GHP)

Specifically, Section 111 of MMSEA provides that GHPs and non-GHP arrangements must share certain information regarding Medicare beneficiaries with the Centers for Medicare and Medicaid Services (CMS).

The Medicare Secondary Payer (MSP) rules refer to the federal statute that provides that Medicare is the secondary payer to some group health plans and to liability insurance (including self-insurance), no-fault insurance, and workers' compensation for medical services provided to certain beneficiaries (called Medicare Beneficiaries). The purpose of the new reporting rules is to ensure that Medicare does not pay for medical claims that should be paid first by another source. The new MSP reporting rules are designed to identify which entity is the primary payer.

This bulletin will provide an overview of the GHP and non-GHP reporting requirements.

Summary of GHP Reporting Requirements

Effective January 1, 2009, an entity serving as an insurer or third party administrator for a GHP

and plan administrators or fiduciaries of a self-insured and self-administered GHP are responsible for gathering certain information about Medicare Beneficiaries and electronically reporting such information to CMS.

A GHP for this purpose means a "plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families." See 26 U.S.C. §5000(b)(1), as referenced in 42 U.S.C. §1395y(b)(7). A health flexible-spending account is not a GHP while a Health Reimbursement Arrangement (HRA) is a GHP for the GHP reporting rules. A Health Savings Account (HSA), under certain circumstances may be considered a GHP.

Who is a Responsible Reporting Entity for GHP Reporting?

The MSP rules provide that an entity serving as an insurer or third-party administrator for a GHP and plan administrators or fiduciaries of a self-insured and self-administered GHP are responsible for complying with the GHP reporting requirements. CMS refers to these entities as Responsible Reporting Entities (RREs).

Any employer sponsoring or participating in a GHP should determine "who" the proper RRE is for the GHP. In general, where a GHP

Bricker & Eckler LLP

100 South Third Street
Columbus, Ohio 43215-4291

Phone 614 . 227 . 2300
Fax 614 . 227 . 2390
info@bricker.com
www.bricker.com

COLUMBUS | CLEVELAND
CINCINNATI-DAYTON

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is fully-insured, the insurer will be considered the RRE. Similarly, where a GHP is self-funded, if the employer has hired a third party administrator (TPA) to process its GHP claims, the TPA will be considered the RRE.

What Information Must Be Provided to CMS?

An RRE must provide CMS's Coordination of Benefits Contractor (COBC) with information regarding hospital and medical GHP coverage that is available to: (1) any individual who meets the definition of an Active Covered Individual, or (2) any individual determined to be a Medicare Beneficiary using CMS's "Query" function. For more information on what individuals are considered an Active Covered Individual, please see the MMSEA Section 111 MSP Mandatory Reporting GHP User Guide.

When Should the Information Be Reported to CMS?

GHP RREs that do not currently exchange data with CMS under the VDSA/VDEA Program are required to register from April 1, 2009, through April 30, 2009, on the COBC's secure website. Once a RRE completes the registration process, CMS will assign the RRE a submission timeline, which will require the RRE to file with CMS no more frequently than quarterly.

Summary of Non-GHP Reporting Requirements

Effective July 1, 2009, an "Applicable Plan" must report information to CMS regarding liability insurance (including self-insurance), no-fault insurance, and workers' compensation claims where the injured party is a Medicare Beneficiary. An Applicable Plan for this purpose means the "following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement: (i) Liability insurance (including self insurance)[,] (ii) no-fault insurance[, and] (iii) Workers' compensation laws or plans." See 42 U.S.C. §1395y(b)(8).

For purposes of the Non-GHP reporting requirements, liability insurance generally includes any policy that provides payment based on legal liability for injury or illness or damage to property, while no fault insurance includes any insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. Some examples of liability and no-fault insurance include, but are not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice

insurance, product liability insurance, employment practices liability insurance and general casualty insurance. Self insurance includes any situation in which an individual, or a private governmental entity, carries its own risk instead of taking out insurance with a carrier.

Finally, workers' compensation includes any law or program administered by a governmental entity to provide compensation to workers for work-related injuries and/or illnesses. The term also includes similar compensation programs where the employer is self-insured or indirectly insured through an insurer.

Who is the Responsible Reporting Entity?

The Applicable Plan is the RRE for non-GHP reporting. Any employer who has an Applicable Plan should determine who the proper RRE is for each Applicable Plan. In general, CMS has indicated that an insurer will generally be considered the RRE for any insured liability policy or no-fault insurance policy. In the case of an entity that self-insures a deductible, the insurer will be considered the RRE to the extent that the payment of the deductible is made through the insurer. If the entity pays the deductible directly to a claimant, then the entity is the RRE. In the case of re-insurance, stop loss insurance, excess insurance, guaranty funds, and patient compensation funds which have insurance beyond a certain limit, the employer will generally be considered the RRE to the extent the payment from the coverage is made to the self-insured entity to reimburse the self-insured entity.

With regard to workers' compensation, to the extent that an employer participates in a workers' compensation plan established by a governmental entity where the agency has the sole responsibility to resolve and pay claims, the agency is the RRE. Where an employer self-insures its workers' compensation, the self-insuring employer is the RRE. If an employer participates in a workers' compensation plan established by a governmental agency where the employer is responsible for self-insuring a per claimant deductible (e.g. the Ohio \$15,000 Medical-Only Program), the employer is the RRE for the claims paid as part of the self-insured deductible and the governmental agency is the RRE for claims paid above the self-insured deductible.

What Information Must Be Provided to CMS?

A RRE must provide CMS's Coordination of Benefits Contractor (COBC) with information regarding the identity of a Medicare Beneficiary whose illness, injury, incident, or accident was at issue and such other information required by the CMS to enable a determination regarding coordination of benefits, including any recovery claim.

Human Resources Law Group

Employment and Labor

James G. Petrie, Chair
614 . 227 . 2373
jpetrie@bricker.com

Donald R. Keller
614 . 227 . 2341
dkeller@bricker.com

Jerry E. Nathan
614 . 227 . 2358
jnathan@bricker.com

Betsy A. Swift
614 . 227 . 8850
bswift@bricker.com

Vladimir P. Belo
614 . 227 . 8885
vbelo@bricker.com

Katherine Spies Giumentti
614 . 227 . 8825
kgiumentti@bricker.com

Thomas R. Sant
614 . 227 . 2331
tsant@bricker.com

Elizabeth C. Stock
614 . 227 . 2323
estock@bricker.com

Cavett R. Kreps
614 . 227 . 2357
ckreps@bricker.com

Lisa M. Kathumbi
614 . 227 . 2326
lkathumbi@bricker.com

Employee Benefits

Christine M. Poth
614 . 227 . 2395
cpoth@bricker.com

Peggy Bomberger
614 . 227 . 4858
pbomberger@bricker.com

Executive Compensation

John P. Beavers, Chair
614 . 227 . 2361
jbeavers@bricker.com

Kevin M. Kinross
614 . 227 . 8824
kkinross@bricker.com

Insurance

Elisabeth A. Squeglia
614 . 227 . 2396
esqueglia@bricker.com

Miranda C. Motter
614 . 227 . 4810
mmotter@bricker.com

When Should the Information Be Reported to CMS?

Any RRE that is required to comply with the non-GHP reporting requirements must register with CMS. A Non-GHP RRE is required to register with CMS between May 1, 2009, and June 30, 2009, on the COBC's secure website. Once a RRE completes the registration process, CMS will assign the RRE a submission timeline, which will require the RRE to file with CMS no more frequently than quarterly. If an RRE hires an agent to undertake its non-GHP reporting, the agent hired may not register on behalf of the RRE. The RRE is required to actually register and designate the TPA as its Account Designee.

Penalties for Non-Compliance With GHP and Non-GHP Reporting

MMSEA contains provisions subjecting the RRE to a civil penalty of \$1,000 for each day of noncompliance for each individual or claimant for which information should have been reported under the GHP and non-GHP reporting requirements.

Common Situations Where GHP and Non-GHP Reporting Are Applicable

In reviewing the GHP and non-GHP reporting requirements, there are several common situations that must be reported under the GHP and/or non-GHP reporting rules. Employers having any of these common situations should familiarize themselves with the new reporting rules. Detailed information on the new reporting rules can be found at the dedicated website maintained by CMS at www.cms.hhs.gov/mandatoryinsrep/01_overview.asp.

Self-Funded Group Health Plan with Stop-Loss Insurance

A self-funded group health plan with stop-loss insurance will generally require GHP reporting and non-GHP reporting. The group health plan will need to be reported under the GHP reporting rules and the stop-loss insurance will need to be reported under the non-GHP reporting rules. In terms of "who" is the RRE for the group health plan, to the extent that the plan sponsor of the group health plan hires a third party claims administrator (TPA), the TPA will be the RRE and have liability for the GHP reporting.

The RRE for the stop-loss insurance will generally be the plan sponsor to the extent that the plan sponsor pays claims that exceed the deductible from the group health plan and the stop-loss insurance carrier reimburses the plan sponsor for such claims.

Self-Insurance Funds (Including Medical Malpractice, Legal Malpractice, and General Liability Funds) with Excess Insurance

Many employers maintain a self-insurance fund for general liability and malpractice claims and couple such fund with an excess insurance policy. Both the self-insurance fund and excess insurance will need to be reported under the non-GHP reporting rules. To the extent that the excess insurance carrier reimburses the employer for claims that exceed the deductible under the self-insurance policy, the employer will be considered the RRE for the excess insurance policy. In this situation the employer will be permitted to submit one report to satisfy the non-GHP reporting requirements for the self-insurance fund and the excess insurance policy.

Workers' Compensation Self-Insured Employers

If an employer participates in a workers' compensation plan established by a State and the State agency has the sole responsibility to resolve and pay claims (e.g. through the Ohio Bureau of Workers' Compensation), the State agency is the RRE. If an employer self-insures its workers' compensation liability and hires a TPA to process its workers' compensation claims, the employer is considered the RRE for the workers' compensation plan under the non-GHP reporting requirements. If an employer participates in a workers' compensation plan established by a State agency where the employer is responsible for self-insuring a per claimant deductible (e.g. the Ohio \$15,000 Medical-Only Program), the employer is the RRE for the claims paid as part of the self-insured deductible and the State agency is the RRE for claims paid above the self-insured deductible.

If you have any questions about this topic or any other labor and employment law issue, please contact Christine M. Poth at 614.227.2395 or cpoth@bricker.com, or Elisabeth A. Squeglia at 614.227.2396 or esqueglia@bricker.com.