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Employment Law Advisory

Group Health Plans, Self-Insured Employers Forced To Begin Registering for Medicare Secondary Payer Reporting Requirements

As a result of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007, which we've addressed in prior communications, all group health plans (GHPs) regardless of whether they are fully-insured or self-insured, faced a January 1, 2009, deadline to begin complying with new reporting requirements to the Centers for Medicare & Medicaid Services (CMS). Next up on CMS's compliance deadline chopping block are the non-GHP responsible reporting entities (RREs): liability insurers (including self-insurers), no fault insurers and workers compensation. These non-GHP RREs must begin reporting to CMS on July 1, 2009. Electronic registration with CMS began for GHPs on April 1, 2009 and for this latter group on May 1, 2009.

The goal of these Section 111 reporting requirements is to keep Medicare as a secondary payer of medical bills by preventing parties from shifting the cost of medical treatment away from the primary payer.

Employers who self-insure and self-administer any plan or process that pays medical benefits must be particularly alert. Employers with self-insured and self-administered GHPs were among the first to register electronically with CMS. Employers who thought they were off the hook by virtue of having a fully-insured GHP or using a third party administrator (TPA) are now finding that they may still be subject to the Section 111 reporting requirements if they self-insure their liability or workers' compensation.

To assist insurers, administrators, and fiduciaries with compliance with Section 111 reporting requirements, CMS has issued an Internet-based Section 111 Reporting User Guide, found at:

<http://www.cms.hhs.gov/mandatoryinsrep/>

Highlights of The CMS Reporting Guide

CMS explains that the purpose of the Section 111 reporting process is to enable CMS to correctly pay for the health insurance benefits of Medicare beneficiaries by determining primary versus secondary payer responsibility. Section 111 authorizes CMS and RREs to make electronic exchanges of health insurance benefit entitlement information. The actual exchange of this data will take place between the RREs and the CMS Coordination of Benefits Contractor (COBC). The COBC will be managing the technical aspects of the Section 111 data exchange process for all RREs.

The Section 111 reporting process includes an option to exchange prescription drug coverage information to coordinate benefits related to Medicare Part D. CMS also allows RREs that are also participating in the Retiree Drug Subsidy (RDS) program or are reporting to RDS on behalf of a plan

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sponsor to use the Section 111 reporting process to submit subsidy enrollment (retiree) files to the RDS Center using the Section 111 reporting process.

GHP RREs Defined. A GHP organization that must report under Section 111 is “an entity serving as an insurer or third party administrator for a group health plan... and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary.” These organizations are Section 111 GHP RREs (to be distinguished from non-GHP RREs). An insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. In instances where an insurer does not process GHP claims but has a third party administrator (TPA) that does, the TPA has the responsibility for those reporting requirements. A TPA is an entity that pays or adjudicates claims and may perform other administrative services on behalf of GHPs, the plan sponsor(s), or the plan insurer. A TPA may perform these services for, among other entities, self-insured employers, unions, associations, and insurers/underwriters of the GHPs. If a GHP is self-funded and self-administered for certain purposes but also has a TPA, the TPA is the RRE.

GHP RREs are required to register with CMS's COBC and fully test the GHP data reporting exchange before submitting production files. Registered GHP RREs are assigned a file submission timeframe during which they must submit files on a quarterly basis.

In short, most GHP RREs are going to be insurers or TPAs, not employers. Employers will be GHP RREs only under very limited circumstances where those employers have self-insured GHPs AND serve as their own plan administrators. For non-GHP purposes (i.e. those RREs subject to the July 1, 2009 compliance deadline), the non-GHP RRE will be the applicable liability insurance plan (including self-insurance), no-fault insurance plan, or workers compensation plan. Be careful though; “plan” is defined loosely. It is likely that some employers will be non-GHP RREs for purposes of these forms of insurance where they self-insure and self-administer. See below for our discussion of non-GHP RREs.

Submission of Reports. Both GHP and non-GHP RREs must submit quarterly reports to the CMS COBC. In exchange, the COBC will provide the RRE with Medicare entitlement information for those individuals that can be identified as Medicare beneficiaries.

GHP RRE Reports. Once the GHP RRE is in a production mode, it must submit to the COBC the initial file containing GHP coverage information for all individuals who are “active covered individuals” in the plan. Subsequent quarterly file submissions are to contain only new or changed coverage information using add, delete and update transactions. “Active covered individuals” are those persons who are covered: (1) in a GHP and are age 45 through age 64 who have coverage based on their own or a family member's current employment status; (2) in a GHP and are age 65 and older who have coverage based upon their own or a spouse's current employment status; (3) in a GHP who have been receiving kidney dialysis or who have received a kidney transplant, regardless of their own or a family member's current employment status; or (4) in a GHP and who are under age 45 are known to be entitled to Medicare, and have coverage in the plan based on their own or a family member's current employment status. When reporting on these under age 45 individuals, the GHP RRE must submit its Medicare Health Insurance Claim Number (HICN).

GHP RREs must provide CMS with information regarding hospital and medical GHP coverage they make available to Medicare beneficiaries. Section 111 also provides for CMS to share information regarding a beneficiary's Medicare Part A (hospital) entitlement, Part B (medical), and Part C (Medicare Advantage) coverage in return. However, CMS has an interest in coordinating benefits related to GHP prescription drug benefits and Medicare Part D (prescription drug) coverage for these same Medicare

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beneficiaries. As a result, CMS has made two reporting options available—basic and expanded—for use in the Section 111 reporting process.

Non-GHP RREs and Reports. For employers who are self-insurers of liability, no-fault insurance or workers compensation (along with other liability, no-fault and workers compensation insurers and TPAs), the Act requires reporting of all claims involving an injured worker who is/was a Medicare beneficiary where settlement, judgment, award or another form of payment is made on or after July 1, 2009, and claims in which ongoing responsibility for medical payments exist as of July 1, 2009, regardless of the date of the claim. Reporting is required quarterly. Subsequent quarterly submissions are to contain only new or changed information about a claim. In the event a settlement, judgment, award or other payment occurs within 45 days prior to the start of the 7 day reporting period, a self-insured employer may submit that claim on the next quarterly reporting period. This grace period will allow self-insured employers time to process the newly resolved claims prior to submission of their mandatory report to CMS. If there have been no changes in the medical or settlement status of any reportable claim since the previous quarterly submission, a self-insured employer must make a quarterly report indicating that no changes have occurred.

CMS will not assist in determining whether an injured worker has or is receiving Medicare benefits. Therefore, we strongly advise self-insured employers to err on the side of reporting all potentially eligible claims. There are no penalties for over-reporting claims. A claim must be reported if there is a settlement, a partial settlement, or the injured worker is eligible to receive further benefits, whether or not they are currently being paid.

Some of the basic information self-insured employers must report to CMS includes: (1) the self-insured employer's name, address, EIN, NAIC, and contact information; (2) the claimant's name, address, social security number, gender, date of injury, telephone number, attorney's name and the address and telephone number of the attorney; and (3) the workers' compensation claim number, ICD code(s) for allowed conditions, date of injury, state in which the claim is filed, and if settled, the date and amount of the settlement.

Penalties for non-compliance with filing obligations. Any RRE failing to comply with these reporting requirements will be subject to a civil money penalty of \$1,000 for each day of noncompliance *for each individual* for which the required information should have been submitted. A civil money penalty is in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim with respect to an individual.

If you have questions about your Section 111 reporting obligations, please call or e-mail Matthew W. Stiles, (205) 323-9275, mstiles@lehmiddlebrooks.com

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