OVERVIEW OF THE NEW MEDICARE SECONDARY PAYER REPORTING RULES

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What are the New Medicare Secondary Payer Reporting Rules?

The Medicare Secondary Payer (MSP) reporting rules refer to the federal statute that provides that Medicare is the secondary payer to some group health plans, and 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.

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

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

Specifically, Section 111 of MMSEA adds mandatory reporting requirements with respect to Medicare Beneficiaries who have coverage under GHP arrangements and who receive settlements, judgments, awards or other payments from liability insurance (including self-insurance), no-fault insurance, or workers' compensation. The information required by the MSP reporting requirements must be reported electronically to the Centers for Medicare and Medicaid Services (CMS).

I. Summary of GHP Reporting Requirements

Effective January 1, 2009, an entity serving as an insurer or third party administrator for a GHP and a plan administrator or fiduciary 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 requirements. A Health Savings Account (HSA), under certain circumstances may be considered a GHP.

Who is a Responsible Reporting Entity for GHP Reporting?

The MSP reporting rules provide that an entity serving as an insurer or third party administrator for a GHP and a plan administrator or fiduciary 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:

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

RREs may use agents to submit data on their behalf. If an RRE hires an agent, the RRE remains solely responsible and accountable for adhering to the MSP GHP reporting requirements and for the accuracy of the data submitted.

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 for: (1) any individual who meets the definition of an Active Covered Individual, or (2) any individual identified through the Finder File reporting option.

For purposes of the GHP reporting requirements, an **Active Covered Individual** includes the following:

- Effective January 1, 2009 through December 31, 2010, all individuals covered under a GHP who are between the ages of 55 through 64 who have coverage based on their own or a family member's current employment status. Effective January 1, 2011 and subsequent years, all individuals covered in a GHP who are between the ages of 45 through 64 who have coverage based on their own or a family member's current employment status.
- All individuals covered in a GHP age 65 and older who have coverage based upon their own or a spouse's current employment status.

- All individuals covered 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.
- All individuals covered in a GHP who are under age 55 (age 45 effective January 1, 2011), are known to be entitled to Medicare, and have coverage in the GHP based on their own or a family member's current employment status.

Essentially, an Active Covered Individual is someone who may be Medicare eligible and is currently employed, or the spouse or other family members of a worker who is covered by the employed individual's GHP and who may be eligible for Medicare. CMS will determine if the Active Covered Individual is a Medicare Beneficiary and whether Medicare is primary or secondary. The results of this determination will be provided to the submitter.

In lieu of submitting information on Active Covered Individuals, an RRE may use Finder File option. Under this option, the RRE sends a query file through which CMS will identify any Medicare Beneficiaries and return the positive identifications to the RRE. The RRE would then submit MSP Input File records for this identified Medicare Beneficiaries. CMS warns that the use of the Finder File method is not as precise as routine reporting of all Active Covered Individuals and may increase an RRE's probability of underreporting all Active Covered Individuals who are Medicare Beneficiaries.

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.

II. 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 purposes of 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*** (including self-insurance) is coverage that indemnifies or pays on behalf of the policyholder against claims for negligence, inappropriate action, or inaction which results in injury or illness to an individual or damage to property. It includes, but is not limited to, the following:

- automobile liability insurance
- uninsured motorist insurance
- underinsured motorist insurance

- homeowners' liability insurance
- malpractice 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. This includes responsibility for deductible.

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 types of limitability insurance include, but are not limited to the following:

- certain forms of automobile insurance
- certain homeowners' insurance
- commercial insurance plans
- medical payments coverage/personal injury protection/medical expense coverage

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:

- 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. However, if the entity pays the deductible directly to a claimant, then the entity is the RRE.
- Where there are multiple defendants involved in a settlement, an agreement to have one of the defendant's insurers issue any payment in obligation of a settlement, judgment, award or other payment does not shift RRE responsibility to the entity issuing the payments. All RREs involved in the settlement remain responsible for their own reporting.
- 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.

- Self-insurance pools will be the RRE to the extent that the self-insurance pool is a separate legal entity with full responsibility to resolve and pay claims using pool funds without involvement of the participating 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.

RREs may use agents to submit data on their behalf. If an RRE hires an agent, the RRE remains solely responsible and accountable for adhering to the MSP non-GHP reporting requirements and for the accuracy of the data submitted.

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.

CMS has established the following guidelines for reporting non-GHP claims:

- RREs are not required to report liability insurance (including self-insurance) or no-fault insurance settlements, judgments, awards or other payments where the date of incident was prior to December 5, 1980.
- RREs must report on claims for which the RRE still has ongoing responsibility for medicals as of July 1, 2009 and the ongoing responsibility for medicals predates July 1, 2009.
- RREs are to report once there has been a settlement, judgment, award or other payment.
- Reporting is not required for a settlement, judgment, award or other payment with no establishment/acceptance of responsibility for on-going medical expenses if the individual is not a Medicare Beneficiary as of the date which must be reported for the settlement, judgment, award or other payment.
- RREs must report settlements, judgments, awards or other payments regardless of whether or not there is an admission or determination of liability. If medical expenses are claimed and/or released, the settlement, judgment, award or other payment must be reported regardless of any allocation made by the parties or a determination by a court.

- RREs are not required to report settlements, judgments, awards or other payments for property damage only claims.

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. However, CMS has indicated that entities who are RREs for non-GHP reporting purposes are not required to register if they will have nothing to report. Such entities who do not register initially because they have nothing to report must register in time to allow a full quarter for testing the data transmission process if they have future situations where they have a reasonable expectation of having to report.

To the extent that a non-GHP RRE decides to initially register with CMS, it is required to do so 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.

III. 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.

IV. 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 MSP reporting rules. Employers that have 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 requirements and the stop-loss insurance will need to be reported under the non-GHP reporting requirements. 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 requirements. 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.