

As indicated earlier this month, we intend to provide you this type of information twice a month. This is the fourth installment and is a work in progress. Therefore, if you have any questions or comments, please direct your questions back to your McGohan Brabender Account Team.

There is a saying that the only thing constant is change. They must have been thinking about employee benefits when they coined that phrase. I try to touch on the most current topics every two weeks in this newsletter. However, there may be times when I reach back further than that just because I find something interesting. In any event, here is this bi-monthly edition of the newsletter.

The health care reform debate seemed to have cooled down over the last couple of weeks as the Democrats regroup after Scott Brown's win in Massachusetts. I am not sure that means health care reform is dead. In fact, President Obama released a "new and improved" version of health care reform and is holding a summit this week to try and revive the legislation. In the meantime let's turn our attention to other things.

Medicare Secondary Payer Rules

The Medicare Secondary Payer Rules have been around for a long time and have been modified over the years. The trend has been to shift the health care burden from the government to the private sector. That is, whenever a person is covered under an employer sponsored group health plan or other coverage and Medicare there are Federal rules to determine which is the primary payer and which is the secondary payer.

The Medicare Secondary Payer Rules can be complex and full discussion of those rules is beyond the scope of this article. However, if the employer has less than 20 employees, Medicare will be primary and the group health plan will be secondary if the person is on Medicare due to age. If the person is receiving Medicare because the person is disabled, Medicare will be primary and the employer's group health plan will be secondary if the employer has less than 100 employees. Finally, the group health plan will be primary and Medicare will be secondary for the first 30 months if the person has end stage renal disease regardless of the number of employees. Again, this is only a summary of the Medicare Secondary Payer Rules.

In the past the government has played "catch up" when it comes to enforcing the Medicare Secondary Payer Rules. That is, the person would go to a provider, usually a hospital, and the person would incur a large claim. The hospital would invoice Medicare and Medicare would pay the invoice. Then a couple of years later the government would discover the person also was covered under an employer sponsored group health plan or had other insurance. The government would then chase the employer and carrier and try to recoup the payment up to three years after the claims had been incurred.

Trying to collect a large amount of money is always a dicey proposition in the first place. On top of that often times the employer has changed insurance companies. That is, the employer could have been with one insurance company when the person was in the hospital and now the employer is with another insurance company when the government contacts the employer trying to collect the money.

The government is trying to cut down on this scenario by being more proactive. In this day of computers and the internet the government is developing a better way to avoid the situation where the government pays the claim and then chases the employer and insurance company for the money. To that end the government has implemented a program where insurance companies and TPAs have to file reports electronically with the government periodically listing people on the employer's group health plan. That way the government will know in advance if the government should pay the claims or if the employer's group health plan is primary. This will, in turn, dramatically cut down the number of times the government pays as the primary payer when, in fact, the government should have been secondary.

The government just announced that it has postponed the mandatory reporting requirements, at least with respect to non-group health plans, until next year. Follow this link to the article:

<http://www.businessinsurance.com/article/20100217/NEWS/100219933>

Again, the postponed reporting requirements only apply to non-group health plans. Note that for group health plans the bulk of the reporting requirements fall on the insurance company and TPA. Therefore most employers will not be impacted that much by the actual reporting requirements.

New Heart Guidance

When I was much younger I used to practice both in the retirement area (e.g. 401K plans, profit sharing plans, etc) and welfare benefit area (e.g. health plans, cafeteria plans, COBRA, etc.). About 15 years ago I gave up on the retirement area and focused in on welfare benefits. Therefore, I know next to nothing when it comes to retirement plan issues. However, I realize most of you deal with both retirement and welfare benefit issues. Therefore, I am going out on limb and attaching a link to an article discussing recently released IRS guidance in the form of questions and answers regarding retirement benefits and military leave under HEART.

<http://tiny.cc/NewHeartGuidance>

I usually end the newsletter by saying if you have any questions or comments call me. However, that does not apply to this article!!

New Mental Health Parity Act Regulations

In the last newsletter I discussed the recently released regulations explaining the Mental Health Parity Act. I am attaching another article. This article contains some examples of how group health plans can comply with the new regulations.

<http://tiny.cc/MentalHealth>

This is a complicated topic. If your health plan is fully insured you should look to the insurance company for help. If you are self funded, your TPA should be able to help you navigate these waters.

Premium Subsidy Appeals

The premium subsidy eligibility is suppose to end on February 28, 2010. That is, under the current rules, only those employees involuntarily terminated on or before February 28, 2010 are eligible for the subsidy. Under the current system the employer determines whether or not the former employee (and his or her family members) are entitled to the subsidy. If the employer denies them the subsidy, they can appeal that decision with the government. The government has recently announced an expedited appeal procedures. The following link will take you to the government's webpage:

<http://www.dol.gov/ebsa/COBRA/main.html>

As previously mentioned there is talk that Congress may extend the subsidy but with all the chaos in Washington it is difficult to predict what will happen with the premium subsidy.

Tax Issues With Extending Health Coverage to Domestic Partners and Older Children

More and more employers are offering health coverage to domestic partners. Ohio recently enacted legislation that will require employers with fully insured health plans to cover certain unmarried children up to age 28. The attached article talks about the tax consequences of providing health care to individuals that are not the employee's spouse or dependent children. Although this article talks about Wisconsin law, the same principals apply to the Ohio statute. That is, the article talks about the Federal tax issues which apply equally to Wisconsin and Ohio individuals.

<http://www.vonbriesen.com/resourcelibrary/FetchArticle.aspx?id=382>

Again, Ohio passed a law requiring all fully insured employer sponsored group health plans in Ohio to cover the employee's unmarried child up to age 28. This rule becomes effective for fully insured health plan in Ohio established, renewed or modified on or after July 1, 2010.

Government Survey on Health Expenditures

If you have a few minutes on your hands and you are so inclined, here is a short article recapping a government survey on health expenditures and the impact on private employers.

<http://www.towerswatson.com/research/1169>

I am not a big fan of surveys but I thought I would throw one in for the heck of it!

New Disclosure Rules Impact Pharmacy Managers

It can be very frustrating for employers sponsoring self funded group health plans to determine exactly how much certain vendors are being paid. The ERISA reporting rules require most plans with 100 or more participants (i.e. employees) on the first day of the plan year file an annual report (i.e. Form 5500) with the government. In the case of a fully insured health plan, it is pretty easy to see how much the broker was paid in commission because the amount is listed on the Schedule A. However, it becomes more difficult if the health plan is self funded. There probably is stop loss coverage and the broker's commissions will, again, be listed on the Schedule A.

However, a number of other vendors are involved with the self funded health plan and their compensation might be harder to find. In an attempt at better disclosure the government has enhanced the reporting obligations by requiring more information be disclosed on the Schedule C. This schedule is used to list compensation that is not disclosed on the Schedule A.

The government has just listed two Q&As that say the pharmacy managers must now disclose their compensation on the Schedule C. This should help plan sponsors be better informed about the plan's total expenses. See the following article about the new disclosure requirements applicable to pharmacy managers.

<http://benefitslink.com/articles/guests/washbull100215.html>

Some employers may get a rude awakening when the true number comes to light.

TPA Held To Be a Fiduciary Contrary to Administration Agreement

For those of you with self funded health plans it is important to review your TPA administration agreements. Very few employers have the expertise to administer their self funded health plan in house. As a result most self funded plan sponsors hire TPAs to administer the plan. Almost universally the TPA will try to avoid fiduciary liability by saying that they simply perform ministerial functions and have no discretionary authority. In short, the TPA is trying to say that it is not a fiduciary under ERISA and, as a result, tries to limit the TPA's exposure.

The TPA will plaster this type of language throughout the administration agreement. That is, the TPA will say that it is not fiduciary under ERISA. However, the courts take a different view. The following is a short article talking about a court in Pennsylvania that ignored the language in the agreement and instead looked at what the TPA was actually doing to determine the TPA's status. In other words, most courts will consider the administrative agreement but will go beyond that document to see exactly what the TPA is doing to determine the TPA's status under ERISA.

http://www.plansponsor.com/Health_Plan_TPA_Still_a_Fiduciary_Despite_Disclaimer.aspx

I am generally not a big fan of including court cases in this newsletter because each lawsuit is unique but I thought this case illustrates an interesting concept.

CHIPRA Notice

As I indicated in this month's earlier edition, everyone should be aware of the new CHIPRA notice requirements. Therefore, I am attaching another article on the topic. Please spend a few minutes getting up to speed on the new rules.

<http://www.millerjohnson.com/pubs/xprPubDetail.aspx?xpST=PubDetail&pub=1767>

This is a short article that does a pretty good job explaining the rules and contains a link to the actual notice.

Catchall Article

The following is an article recapping significant changes and upcoming deadlines.

<http://www.reinhartlaw.com/Publications/Documents/ea%20201002%20EB.pdf>

This article talks about both welfare benefit and retirement issues.

If you have any questions concerning any of the topics (other than the disclaimer regarding the HEART article), please contact me.