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CMS Guidance On Health Plan Reporting Requirement

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) imposes a new reporting requirement on group health plans that cover Medicare-eligible individuals. The Centers for Medicare and Medicaid Services (CMS) has begun to issue guidance on this new requirement, which becomes effective in 2009.

Background

Most employer health plans that coordinate benefits with Medicare are subject to special ordering rules known as the Medicare secondary payer rules. These rules are complex, but generally require that the employer plan be the primary payer for expenses incurred by a participant or the participant's spouse if the participant has coverage by reason of his or her current employment status. An employee may elect to have Medicare as the primary payer, in which case the employer plan is prohibited from reimbursing those expenses on a secondary basis.

Medicare is the primary payer for (1) retirees and their spouses, (2) disabled individuals (unless heath plan coverage is based on their own or a family member's current employment status), and (3) individuals with end stage renal disease during a coordination period of 30 months.

Currently, CMS enforces the Medicare secondary rules through random audits of group health plans. Some plans have entered into agreements with CMS to provide group health plan enrollment information to the agency in exchange for participants' current Medicare status. The purpose of these agreements, known as voluntary data sharing agreements (VDSAs), is to facilitate the correct order of benefit payment.

MMSEA Reporting Requirement

The new reporting requirement under MMSEA builds on the voluntary data sharing program. It requires a "responsible reporting entity" to submit information to CMS to help in the identification of situations in which the group health plan is, or has been, primary to Medicare. A responsible reporting entity is an insurer, a third party administrator, or, in the case of a health plan that is both self-insured and self-administered, the plan administrator or fiduciary. Financial penalties apply to a responsible reporting entity that does not make the required filings.

> ***BUCK COMMENT.*** *As long as the plan sponsor does not administer claims under its group health plan, it will not be a responsible reporting entity, and so not subject to statutory penalties.*

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The type of information to be submitted and the timeframe for submitting it are not specified in the law, but are to be specified by the Secretary of Health and Human Services. In August 2008, CMS established a website dedicated to these new rules. Since then, CMS has been populating that site with guidance for reporting entities. Notable releases to date include –

- **An implementation timeline**. The reporting requirements are phased in over a 12-month period from October 1, 2008 to October 1, 2009. Reporting entities that currently have a VDSA with CMS will begin the required reporting between October 1, 2008 and March 31, 2009, while other reporting entities will begin reporting between April 1, 2009 and September 30, 2009.
- **Group health plan paper registration process**. This applies only to reporting entities that have a VDSA in place and so are in the first group to submit reports.
- **A list of required data elements for group health plan reports**. This list includes information that the reporting entity may have to request from covered participants (e.g., spouses' Social Security numbers).

BUCK COMMENT. *Responsible reporting entities may need assistance from the plan sponsor in collecting this information. Accurate and complete information from the plan sponsor will enable the reporting entity to meet its obligations and avoid penalties.*

Further guidance is expected in a number of areas, including clarification of the types of group health plans that are subject to the reporting requirement. For example, although dental plans fall within the statutory definition of a group health plan, they do not coordinate with Medicare because they provide benefits that Medicare does not cover. Thus, there would seem to be no reason to report this coverage to CMS.

Conclusion

Employers are directly subject to the MMSEA reporting requirement only if they self-administer a self-funded group health plan. Other employers, although not directly affected, may be asked to assist the responsible reporting entity in the collection of beneficiary data. Unless the responsible reporting entity has a current VDSA with CMS, the reporting process will not begin until April 1, 2009.

Buck's consultants will be monitoring the CMS guidance as it is issued and would be happy to discuss this reporting requirement with you.