



# EMPLOYEE BENEFITS BULLETIN

April 20, 2009

## *Medicare As Secondary Payer Reporting Requirement*

### **Summary**

As reported previously, in late 2007, President Bush signed into law the Medicare, Medicaid and SCHIP Extension Act of 2007 ("the Act") which sets forth new Medicare Secondary Payer ("MSP") data-reporting requirements with respect to group health plans ("GHPs").

Effective January 1, 2009, carriers and third party administrators ("TPAs") of GHPs must gather information from plan sponsors and plan participants to identify situations in which the GHPs are or have been primary to Medicare and submit the information to the Department of Health and Human Services ("HHS"). For plans that are self-insured and self-administered, a plan administrator or fiduciary must gather and submit the required information.

There is an extension to the deadline for health reimbursement arrangements ("HRAs").

Different rules apply with respect to reporting as to liability insurance, no fault insurance, and workers' compensation laws or plans.

### **Details**

#### Purpose

The purpose of the new reporting requirement is to identify situations where the employer and not the government pays primary.

Generally, when a participant is covered under both a GHP and Medicare, Medicare will be a secondary payer unless the participant is covered as a retiree.

#### Reporting

On a quarterly basis, a responsible reporting entity ("RRE") of a GHP must report various data elements, including social security numbers, as to active covered individuals.

#### RREs

Carriers and TPAs of GHPs are RREs unless a plan is self-insured and self-administered in which case a plan administrator or fiduciary is the RRE.

#### Active Covered Individuals

Active covered individuals are:

- Effective January 1, 2009 through December 31, 2010, all individuals covered in a GHP age 55 through age 64 who have coverage based on their own or a family member's current employment status. Effective January 1, 2011 and following, all individuals covered in a GHP age 45 through age 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 plan based on their own or a family member's current employment status. When reporting on individuals under age 45, their Medicare Health Insurance Claim Number should be submitted.

COBRA continuees (other than those receiving dialysis or who have had a kidney transplant) are not considered active covered employees and should not be reported.

### Group Health Plans

Major medical plans and HRAs are GHPs.

Health FSAs and HSAs are not required to be reported.

While stand-alone dental and vision care coverage need not be reported, RREs are responsible for being aware of situations where dental or vision care services are covered by Medicare and should be paid primary to Medicare.

### HRAs and Deductible Reimbursement Plans

HRAs are GHPs subject to the reporting requirements. CMS extended the initial reporting deadline for HRAs to fourth quarter 2010 (October – December). This extension is welcome news to TPAs and employers self-administering these programs as this delay will allow RREs more time to update their systems and collect the required information.

There are still a number of unanswered questions regarding HRAs and other self-insured medical reimbursement programs. CMS indicated it will release additional guidance to address the reporting requirements associated with these programs.

It is not known whether certain self-insured medical reimbursement plans (e.g., deductible reimbursement plans) will receive a special exclusion for purposes of the reporting requirement (much like health FSAs and HSAs receive). Under the current guidance, it would appear that these plans should be treated like HRAs and therefore are subject to the requirement. This will impose significant compliance obligations on employers self-administering these arrangements.

These requirements are highly technical and will require significant resource investment in IT as well as human resource staff. Plan sponsors administering these arrangements in-house may want to consider hiring a TPA to administer these programs.

### Data Elements

The data elements include demographic data (i.e., name, date of birth, sex, employment status, social security number, relationship to participant, etc.) and information about the GHP (i.e., employer size, policy number, employer identification number, etc.). For GHPs that have not previously collected participant and/or dependent social security numbers, such information must be collected. Social security numbers must be reported with the first report in 2009 for (i) all participants and (ii) dependents whose initial date of coverage is on or after January 1, 2009. Social security numbers for dependents whose initial date of coverage is prior to January 1, 2009 are not required to be reported until the first file submission in 2011.

### Why Carriers and TPAs Are Bothering Clients Now

The big item that carriers and TPAs often do not have is the social security number for dependents.

This new requirement was issued in 2007. Carriers and TPAs should have required this information in connection with open enrollment materials or requested it from employers in advance, but did not. Outside of a contractual agreement with the carrier or TPA, there is no requirement that employers comply with carrier or TPA requests for this information.

### Shared Information

The Act also requires HHS to share information on Medicare Part A entitlement and Part B enrollment with GHP insurers, TPAs, plan administrators, and fiduciaries; authorizes (but does not require) HHS to share Medicare Part A entitlement and Part B enrollment information with others; and authorizes HHS to share the information it gathers under the new reporting system as necessary for proper coordination of benefits.

### Registration/Reporting Dates

Generally, an RRE must register with CMS before sending a reporting file. For RREs that have not participated in voluntary information-sharing arrangements with CMS prior to 2009, the registration period is April 1, 2009, through April 30, 2009. Although the file submission is required on a quarterly basis, CMS has divided each calendar quarter into twelve (12) "submission periods." Following registration, each RRE will be assigned to a "group" corresponding to one of the submission periods. Based on the group assignment, the date on which an RRE must submit each quarterly file could be as early as seventh day of the first month of each calendar quarter and as late as the last day of each calendar quarter.

## Penalty

There is a hefty fine for non-compliance: a civil monetary penalty of \$1,000 for each day of noncompliance for each individual for which information should have been submitted. This fine is in addition to any other penalties prescribed by law and any potential claims under the MSP regulations (e.g., a claim by Medicare that the GHP should have paid primary to Medicare).

## Liability Insurance, No Fault Insurance, and Workers' Compensation

TPAs are never RREs for purposes of liability insurance (including self-insurance), no fault insurance, and workers' compensation laws or plans; the employer is the RRE.

RREs may contract with an entity such as a TPA to act as an agent for reporting purposes. Registration for reporting and file submission must be completed by the RRE. During registration, the RRE may designate an agent. An agent may not register on behalf of an RRE. An RRE may not shift its reporting responsibility to an agent, by contract or otherwise. The RRE remains solely responsible and accountable for complying with the reporting requirements and for the accuracy of data submitted.

These non-GHP requirements are effective **July 1, 2009**.

## Additional Information

For additional information, visit: <http://www.cms.hhs.gov/MandatoryInsRep/>

The user guide for GHPs is available at:

[www.cms.hhs.gov/MandatoryInsRep/Downloads/030409GHPUserGuide.pdf](http://www.cms.hhs.gov/MandatoryInsRep/Downloads/030409GHPUserGuide.pdf)

For information for non-GHPs, visit:

[http://www.cms.hhs.gov/MandatoryInsRep/03\\_Liability\\_Self\\_No\\_Fault\\_Insurance\\_and\\_Workers\\_Compensation.asp#TopOfPage](http://www.cms.hhs.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.asp#TopOfPage)

<http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf>

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