

MANDATORY CMS REPORTING REQUIREMENT AND HRAs

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added a new mandatory reporting requirement for group health plans, liability insurance, no-fault insurance and worker's compensation.

For group health plans, the law requires Responsible Reporting Entities (RREs) to provide information to the Centers for Medicare and Medicaid Services (CMS) to better coordinate payer responsibilities between the group health plan and Medicare. An RRE of a group health plan will be one of the following entities:

- The insurer in a fully insured arrangement;
- The third-party administrator (TPA) in a self-funded arrangement where the TPA acts as the claims administrator; and
- The employer/plan administrator in a self-funded and self-administered arrangement.

Most group health plans, except stand-alone dental and vision plans, health FSAs and HSAs, are required to report information to CMS.

CMS recently provided guidance on the reporting requirement for Health Reimbursement Arrangements (HRAs). Previous guidance delayed the effective date for reporting on an HRA until fourth quarter 2010 and indicated that clarification on this requirement would be forthcoming.

In the guidance, CMS considers an HRA to be a group health plan subject to the reporting requirement with limited exemptions. The term "HRA" is defined broadly for purposes of this requirement and generally includes arrangements that are 100% funded by the employer. This includes HRAs with and without carryovers; it may also include deductible reimbursement arrangements funded by the employer and medical reimbursement accounts (MRAs).

Some key points from the guidance include:

- HRAs with an annual benefit value of less than \$1,000 are exempt from reporting.
- Retroactive reporting is not required. Only HRA coverage with effective dates of October 1, 2010 and subsequent will be reported to CMS. However, the guidance does not clarify the term "effective date." Is it any HRA existing on October 1, 2010, or would it apply to the first HRA plan year beginning on or after October 1, 2010? Further guidance is needed.

- Reporting is required on HRAs that are “free-standing,” meaning that it is not linked to other group health plan coverage. If the HRA is linked to other group health plan coverage, it should be included with the reporting for that coverage. From an administration standpoint, this may be confusing. Many programs tie the HRA to the group health plan; however, in some cases, the group health plan and HRA administrator are different entities. It is not clear whether the HRA administrator would provide information to the group health plan or if they would file on the plan as a free-standing arrangement. Guidance would be helpful.

Most employers hire a TPA to oversee claims administration of HRAs. The TPA will have the responsibility to complete this reporting function. Employers may notice that more information is requested from their participants on enrollment forms associated with the HRA in order to comply with the requirements. However, the overall burden on an employer is expected to be minimal.

Employers who currently self-administer the HRA may want to consider outsourcing this function, as compliance with the reporting requirement is extremely burdensome and will require technical resources and assistance for benefit administrators in order to properly provide the required information.

More information is available in the *MMSEA Section 111 MSP Reporting Guide – GHP User Guide*, on page 68:

<http://www.cms.gov/MandatoryInsRep/Downloads/GHPUserGuideV3.pdf>.

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