

MANDATORY REPORTING REQUIREMENT FOR GROUP HEALTH PLANS

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (the Act) (P.L. 110-173) imposes a mandatory reporting obligation on group health plans. The purpose of this new requirement is to better identify and coordinate instances where group health plans are (or should be) paying primary to Medicare. Provisions of the Act are effective January 1, 2009. The Centers for Medicare and Medicaid Services (CMS) has provided guidance addressing the new requirement. Following summarizes key aspects of their guidance.

Who Must Report?

The Act requires reporting entities to provide certain required information to CMS for the purpose of coordination of benefits. A reporting entity includes:

- Group health plan insurers;
- Third-party administrators; and
- In the case of self-administered and self-insured plans, the plan administrator or fiduciary.

In most cases employers are not reporting entities and therefore will not be responsible for the reporting requirement; the burden is on their insurer or TPA.

- For fully insured group health plans, the insurance company has the obligation to provide the mandatory reporting to CMS.¹
- For self-insured arrangements administered by a TPA who processes and adjudicates the group health plan's claims, the TPA will be responsible for the reporting.²
- It is only in a very limited scenario, where the employer both self-insures and self-administers the group health plan (i.e. processes claims in-house) that the plan sponsor has the obligation to report to CMS. **Most self-insured plans are not established in this manner.**

¹ For purposes of the reporting requirement the insurer is an entity that, in return for receipts of premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. *Supporting Statement for the Medicare Secondary Payer Mandatory Insurer Reporting Requirement – Attachment A Definitions and Reporting Obligations* (<https://www.cms.hhs.gov/MandatoryInsRep/Downloads/SupportingStatement082808.pdf> as visited Oct 14, 2008)

² For purposes of the reporting requirement, the TPA is an entity that pays and/or adjudicates claims (and may perform other administrative services) on behalf of the group health plan, group health plan sponsor, or in some cases an insurer. The TPA has the responsibility to provide the mandatory reporting to CMS. *Supporting Statement for the Medicare Secondary Payer Mandatory Insurer Reporting Requirement – Attachment A Definitions and Reporting Obligations* (<https://www.cms.hhs.gov/MandatoryInsRep/Downloads/SupportingStatement082808.pdf> as visited Oct 14, 2008)

Active Covered Individuals

The Act requires the insurer or TPA to make a disclosure to CMS on all “active covered individuals” under the group health plan.

The guidance defines an “active covered individual” as:

- All individuals covered by a group health plan age 45-64 who have coverage based on their own or a family member’s current employment status;
- All individuals covered by a group health plan age 65 and older who have coverage based on their own or a spouse’s current employment status;
- All individuals covered by a group health plan 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; and
- All individuals covered by a group health plan who are under age 45, 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.

Social Security Numbers & Medicare Health Insurance Claim Numbers

CMS seeks to collect a number of data elements from the group health plan including Social Security Numbers (SSNs) and the associated Medicare Health Insurance Claim Numbers (HICNs). Insurers and TPAs of group health plans will be required to provide SSNs of all active covered individuals (employees, spouses and dependents) in their disclosure.

CMS recognizes that some reporting entities may not have a practice of collecting SSNs of spouses and dependents of the covered employee. CMS is providing for a limited extension with respect to the collection of certain active covered spouses/dependents SSNs. For spouses and dependents initially covered by the group health plan **before January 1, 2009**, reporting entities will not be required to submit records with SSNs for those covered spouses/dependent until first quarter 2010. This extension does not apply to the subscriber (employee) and does not apply if initial coverage for the active covered spouse/dependent occurred on or after January 1, 2009. Plans taking advantage of this reporting exception will need to report on all dependent/spouses in their first quarter 2010 filing. The report will be retroactive and include all dependents with coverage prior to 1/1/2009 which was still active on 1/1/2009. For example, if you cover the spouse of an employee whose coverage was effective 1/1/2006 and his coverage is still active as of 1/1/2009, but you do not have his SSN on file, you can delay reporting on this spouse until first quarter 2010.

SSNs are treated as protected health information under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such information will be collected and maintained in accordance with the HIPAA privacy requirements.

In many cases the insurer or TPA receives the SSN of covered employees and their dependents as a part of the group health plan enrollment process. However, there may be occasions where the insurer or TPA does not have this information. In such instances the insurer or TPA may request assistance from the employer in collecting social security numbers in order to meet the compliance requirement.

Collection Process

Many insurers and TPAs are already reporting much of the required information to CMS through Voluntary Data Share Agreements (VDSAs) or Voluntary Data Exchange Agreements (VDEAs). According to CMS, reporting entities currently participating in these arrangements will see little to no additional burden in their reporting practices for compliance with this new requirement.

Entities that currently do not report to CMS under the VDSA/VDEA will need to work with CMS to establish their reporting protocol. Registration will be electronic through the CMS Web site.

Timing

CMS has provided initial guidance on the implementation timeline for this new reporting requirement.

- Group health plans that currently participate in the VDSA/VDEA with CMS will begin the data transmission process starting January 1, 2009.
- For group health plans that currently do not participate in the VDSA/VDEA, the initial testing of the data exchange is scheduled to begin April 1, 2009, with a first submission scheduled to begin July 2009.

By October 1, 2009, all reporting entities will be submitting reports to CMS under this Act.

Monetary Penalties for Noncompliance

Insurers and TPAs failing to comply with the requirements under the Act shall be subject to a penalty of \$1,000 for each day of noncompliance for each active covered individual for whom information should have been submitted.

Other Compliance Considerations – HRAs

CMS recently commented that HRAs administered by a TPA or in-house by an employer may be subject to this new reporting requirement as HRAs are considered group health plans for purposes of Medicare Secondary Payer requirements. This would impose a significant burden on HRA administrators and those employers who self-insure and self-administrator the HRA as much of the information required by the Act, including SSNs of the employees, spouses and dependents, are not regularly collected. CMS is reviewing this issue and will release guidance specifically dealing with the applicability of the mandatory reporting on the HRA. If reporting is required, the HRA administrator (or employer) would likely begin the process April 1, 2009, collecting information back to January 1, 2009. Health FSAs and HSAs appear to be exempt for the reporting requirement.

Conclusion

Guidance from CMS is still forthcoming on many aspects of the reporting requirement. While most employers will not have a reporting requirement under the Act, they may be requested to assist their insurer or TPA in the collection of social security numbers. Kibble & Prentice is working with our insurers and TPAs to understand their current information collection process and whether you will be impacted by this process in the coming year. We will continue to keep you posted as additional information develops.

For more information, visit the CMS Web site on Mandatory Insurer Reporting:

www.cms.hhs.gov/mandatoryinsrep/01_overview.asp.

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