# New Medicare Secondary Payer Reporting Requirements For Group Health Plans

**By Charles M. Cain II and B. David Joffe**

Effective January 1, 2009, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (the "Act") amended the Medicare Secondary Payer rules to require insurers, third-party administrators ("TPAs"), and (in the case of self-funded plans) plan administrators of group health plans (collectively referred to as responsible reporting entities ("RREs")) to obtain certain information about individuals covered under the plan and submit such information on a quarterly basis to the Centers for Medicare and Medicaid Services ("CMS"). Generally, the reporting requirement is intended to provide CMS with information regarding Medicare beneficiaries who are covered by group health plans for the purpose of coordinating Medicare benefits with such group health plans.

## Group Health Plans

Generally, a group health plan means an arrangement of, or contributed to by, one or more employers or employee organizations to provide health benefits or medical care for current or former employees and their families. The definition of a group health plan excludes flexible spending arrangements, health savings accounts, stand-alone dental plans, and stand-alone vision plans. However, the definition includes health reimbursement arrangements.

## Responsible Reporting Entities

An RRE is "an entity serving as an insurer or third-party administrator for a group health plan ... and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary." For purposes of the Act, a TPA is "an entity that pays and/or adjudicates claims and may perform other administrative services on behalf of [group health plans]." Generally, an employer whose health plan is fully insured or, in the case of a self-funded arrangement, administered by a TPA will not be an RRE. Accordingly, the insurer or the TPA, rather than the employer, will be liable for any penalties for failures to comply with the Act. However, if an employer has a group health plan that is self-funded and does not utilize a TPA to adjudicate or pay claims for such plan, the plan administrator will be an RRE and will be required to meet the reporting requirements of the Act.

For employers that have fewer than twenty (20) employees and maintain a single-employer plan, the Act does not require reporting with respect to Active Covered Individuals ("ACIs") based on age. However, as explained below, small employer plans are still required to report with respect to ACIs who have undergone kidney dialysis or a kidney transplant.

**Reporting Requirements**

The Act requires RREs to report at least twenty-three (23) data elements for each ACI. For purposes of the Act, ACIs are:

- all individuals covered by a group health plan who are age 55 (age 45, effective January 1, 2011) through age 64 and have coverage based on their own or a family member's current employment status;
- all individuals covered by a group health plan who are age 65 or older and have coverage based on their own or their spouse's current employment status;
- all individuals covered by a group health plan who have undergone kidney dialysis or a kidney transplant, regardless of their own or their family member's current employment status; and
- all individuals who are under age 55 (age 45, effective January 1, 2011), are known to be Medicare eligible, and have coverage based on their own or their family member's current employment status.

Except for an individual who is receiving kidney dialysis or has had a kidney transplant, an individual covered under a group health plan through the Consolidated Omnibus Reconciliation Act of 1986 is not considered an ACI.

Generally, the data elements required to be reported for ACIs are already collected through the enrollment process for most group health plans. The data elements include demographic data (i.e., name, date of birth, sex, employment status, relationship to participant, etc.) and information about the group health plan (i.e., employer size, policy number, employer identification number, etc.). However, for group health plans that do not collect 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) participants, and (ii) dependents whose initial date of coverage is after January 1, 2009. Social Security numbers for dependents whose initial date of coverage is on or before January 1, 2009, are not required to be reported until the first file submission in 2011.

**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.

**Penalties**

If an RRE fails to report the required information by the deadline for its submission period, the RRE will be subject to a civil penalty of $1,000 per person for each day of non-compliance. For example, if an RRE failed to report for a group health plan that had one hundred (100) ACIs, the RRE could be subject to a penalty of $100,000 per day.

**Action Items for Group Health Plan Sponsors**

Although most group health plan sponsors will not be RREs, plan sponsors should take steps to guarantee that their insurers or TPAs are prepared to comply with the Act. While the Act provides that only an RRE will be liable for penalties, plan sponsors should (1) review the reimbursement and indemnity provisions of the contracts with their insurer or TPA with respect to penalties in connection with the plan, and (2) contact their insurers or TPAs regarding additional data elements that may be needed from participants and dependents covered under their plans.

If you have any questions about the reporting requirements, please contact one of the Employee Benefits and Executive Compensation attorneys at Bradley Arant Boult Cummings LLP.


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