Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)

Below is information on the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). Section 111 of the Act, added mandatory reporting requirements for group health plans and for non-group health plan arrangements (liability insurance including self-insurance, no-fault insurance, and workers' compensation). They require insurers for group health plans, or in the case of self-insured plans, TPAs, to provide specified information to CMS for individuals who may be eligible for Medicare. If a group health plan is self-insured and self-administered, the reporting requirement falls on the plan administrator or plan fiduciary.

Health Reimbursement Arrangements (HRAs) generally are required to comply with the Medicare Secondary Payer (MSP) mandatory reporting requirements. Whether a particular HRA will need to be reported, however, will depend in part on the amount of its annual benefit. For purposes of the special HRA mandatory reporting requirements, coverage will be considered to be an HRA "regardless of whether it has an end-of-year carry-over or roll-over feature", so long as it is "funded 100% by an employer". Thus, the MSP mandatory reporting definition of HRA is much broader than the tax definition in that employer-funded accounts that forfeit each year (e.g., deductible reimbursement plans) will be considered HRAs even though they do not include a carryover feature.

Delayed Effective Date for MSP Mandatory Reporting for HRAs

Although the MSP mandatory reporting requirements generally became applicable for group health plans beginning January 1, 2009, HRAs did not become subject to the reporting requirements until October 1, 2010, and were not required to report retroactively. As a result, only HRA coverage with an effective date of October 1, 2010 or later must be reported.

Delayed RRE Registration Date for HRA-Only TPAs

HRA-only Required Reporting Entities (RREs) (i.e., RREs that report only HRA data and do not report data for any other type of group health plan) were required to register with CMS beginning May 1, 2010, in order to complete the registration process by June 30, 2010.

Entities that are RREs are not required to register with CMS if they will have nothing to report. For example, a TPA that administers and pays claims only for certain stand-alone or "carve-out" group health plan coverage that does not overlap Medicare coverage (e.g., dental or behavioral health) may not have anything to report to CMS. In that situation, the TPA would not have to register with CMS as an RRE. Entities that do not register with CMS as RREs because they have no expectation of having group health plan coverage to report, however, must timely register if they have future situations where they have a reasonable expectation of having to report.

So, by way of further example, if an employer converts its stand-alone limited-purpose HRA into a general-purpose HRA that pays or reimburses all Code §213(d) medical expenses not covered by the employer's major medical plan, the entity that administers the general-purpose HRA would have to register with CMS as an RRE.

HRA Coverage Must Be Reported Separately Even If It Is "Linked" With Other Coverage

CMS guidance had initially indicated that only "free-standing" HRAs not linked to other group health plan coverage would need to be reported, and that HRA coverage that is imbedded or part of a more comprehensive or "standard" group health plan would be reported along with the standard group health plan coverage (not separately). However, in a subsequent version of the User Guide, CMS reversed this position and decided to require reporting with respect to all nonexempt HRA coverage, without regard to whether the coverage is linked or offered on a stand-alone basis.

As a result, RREs may need to submit two records for an individual: one for the individual's HRA coverage, and another for the individual's standard group health plan coverage. If the RRE for the HRA is not the same as the RRE for the other group health plan, the RRE for the HRA (or its agent) will need to submit records only for the HRA.

Exception for "Small-Dollar" HRA Coverage

MSP mandatory reporting for an HRA is not required if the annual benefit is below the dollar threshold established by CMS. **Effective October 3, 2011, new or renewing HRA coverage does not have to be reported if its annual benefit is less than $5,000**. Prior to that date, the reporting threshold for HRAs was $1,000. Coverage that was subject to the old ($1,000) threshold remained subject to that threshold until it was renewed.

CMS officials have indicated that this exemption is based on the coverage level at the beginning of the year (e.g., how much is reflected in the HRA account) and not on claims paid. Amounts carried over from previous years must be included when determining whether the current year's annual benefit is less than the applicable reporting threshold. CMS officials have also informally indicated that HRAs with balances that may increase during the year (e.g., based on hours worked, or ratably throughout the year) do not need to report until the annual accruals equal or exceed the reporting threshold. Note, however, that even if HRA coverage qualifies for this exemption from MMSEA mandatory reporting, such coverage will likely still be subject to the MSP requirements.

While the User Guide indicates that termination dates should not be submitted when the annual benefit value of an HRA drops below the $1,000 threshold or is exhausted, CMS has now reversed this position. Under the new rule, which became effective September 27, 2011, a notice of termination must be submitted to the Coordination of Benefits Contractor (COBC) when an HRA participant's benefit is exhausted, but only if no additional HRA benefits will accrue for the remainder of the coverage term. To facilitate reporting of coverage terminations, notice of terminations may be given to the COBC in the next regularly scheduled MSP Input File submission or by calling the COBC Call Center. If a notice of termination is given and at the start of the next HRA benefit period the individual once again has an HRA benefit that must be reported (i.e., because it is $5,000 or more), the responsible reporting entity must submit a new record of coverage information (referred to by CMS as an "add record") reflecting the start date of the new coverage period.

For What Individuals Will Reporting Be Required?

If MSP mandatory reporting is required, the RRE for a group health plan will be required to provide information to CMS for all individuals meeting the definition of an "active covered individual". In general, an active covered individual is someone who may be Medicare eligible and currently is employed, or the spouse or other family member of a worker who is covered by the employed individual's group health plan and who may be eligible for Medicare and for whom Medicare would be secondary payer.

MSP Mandatory Reporting Applies to Same-Sex Spouse. Any individual who is entitled to Medicare as a spouse based on the Social Security Administration's rules is considered a spouse for purposes of the MSP working aged provisions. Both parties to a same-sex or opposite-sex marriage are spouses for this purpose if the marriage is valid in the jurisdiction in which it was performed.[*] Entities that are responsible for complying with the MSP mandatory reporting requirements (referred to as responsible reporting entities or RREs) should take this new rules into account when reporting information to CMS about individuals who are entitled to Medicare and are covered under a group health plan. The rules, including proper MSP mandatory reporting, must be implemented no later than January 1, 2015.

[*] CMS Alert: Medicare Secondary Payer (MSP) Working Aged Policy for Group Health Plans (GHP)—Definition of "Spouse"; Same-Sex Marriages (June 3, 2014) (as visited July 17, 2015). MMSEA Section 111 MSP Mandatory Reporting GHP User Guide, Version 4.7, §7.2.7 and Appendix F (July 13, 2015) (as visited July 17, 2015).

For MSP mandatory reporting purposes, CMS has defined "active covered individuals" to include the following individuals:

- those covered in a group health plan age 45 through 64 who have coverage based on their own or a family member's current employment status;
- those covered in a group health plan age 65 and older who have coverage based upon their own or a spouse's current employment status;
- those who have been receiving kidney dialysis or have received a kidney transplant, regardless of their own or a family member's current employment status and regardless of their age; and
- those covered in 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.

The User Guide includes numerous examples of who are (and who are not) active covered individuals. For example, a subscriber, age 55, is an employee of a company that has had more than 19 employees for the last several years. His wife, age 56, is also covered by the group health plan. Both the subscriber and his spouse are active covered individuals due to their age. Coverage information should be submitted to CMS for each of these individuals on separate reporting records.

CMS expects that an RRE "knows" that an individual is entitled to Medicare if there is a Health Insurance Claim Number (HICN) on record, or they are paying primary or secondary to Medicare for a covered individual that has group health plan coverage based on the subscriber's current employment status. Thus, the RRE should check its internal enrollment, other insurance or coordination of benefits files or claims payment records for these circumstances. It does not mean that the RRE should send a query record for every covered individual under the age threshold if it has no reason to believe these individuals are entitled to Medicare.

Here is the link to the User Guide. https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/MMSEA-Section-111-GHP-User-Guide-Version-47-July-13-2015.pdf