

Federal Legislative Brief

New Secondary Payer Requirements Impact 2008-17



On August 1, 2008 the Centers for Medicare and Medicaid Services (CMS) issued broad guidelines (Supporting Statement) for implementing a mandatory data reporting requirement which effects group health plans, whether insured or self-insured. As of January 1, 2009, insurers and third party administrators (TPAs) must collect and report information on all Medicare eligible plan participants, their coverage election including type of coverage (e.g., HMO, PPO, etc), group policy numbers (if applicable) and other data specifically on drug plan availability. Plan Sponsors may need to provide participant-specific information to insurers and TPAs in support of the CMS mandate. If a health plan is self funded and self administered, then the burden falls on the Plan Administrator/Fiduciary to meet there requirements.

The purpose of this memorandum is to alert Plan Sponsors to the CMS guidelines and to encourage them to verify that their insurers and TPAs, if applicable, are taking all actions necessary to meet the CMS actions necessary to meet the CMS requirements or take the necessary action to achieve compliance.

Background

The CMS guidelines resulted from the passage of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) enacted on December 29, 2007 with implementation dates of January 1, 2009 (Health Plans) and July 1, 2009 (auto liability and similar plans).

The MMSEA applies to group health plans, liability insurance with a medical component, no-fault auto policies, and workers compensation, regardless of whether the plans or policies are insured or self insured.

Prior to the passage of this law, CMS had entered into Voluntary Data Sharing Arrangements (VDSAs) with most all large insurers. The insurers who have VDSAs in place will meet the new compliance obligations with MMSEA. As a result, CMS does not perceive compliance as burdensome on the employer.

Details

- 1. Role of the Plan Sponsor.** Plan Sponsors whose plans are insured as well as those whose plans are administered by large well qualified TPAs will not find the new reporting requirement burdensome. However, some TPAs for self-insured plans may not have collected all of the data necessary to meet the new reporting requirement. In that instance, the Plan Sponsor may need to collect and remit new data (e.g. HIC numbers, social security numbers, etc.) to the TPA.

If the Plan Sponsor administers its own plan, they have to choose between reporting the data itself or retaining a TPA or other vendor to do it on its behalf. In this instance the Plan Sponsor retains the ultimate responsibility for compliance.

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2. **Data Requirements.** Basically, CMS intends to use the data collected to manage its Medicare Secondary Payer and Medicare Part-D processes. As a result, it desires to collect data on the following plan beneficiaries (including spouses and dependents):
 - a. Covered under group health plan who are age 65 and older with coverage under a plan sponsored by an employer with 20 or more employees;
 - b. Age 65 or older and have coverage under a working spouse's employer-sponsored health plan (an employer with 20 or more employees);
 - c. Beneficiaries with end-stage renal disease covered under the group health plan as primary for up to 30 months;
 - d. Are disabled and have coverage as an employee or a dependent under a group health plan sponsored by an employer with 100 or more employers.

Please refer to Attachment A for a list of the data elements CMS has identified for collection from group health plans. It is important to note that even if you do not have any active employees over age 65, you may have spouses or dependents who are Medicare eligible.

3. **Submission Process.** CMS requires the reporting entity (insurer, TPA, etc.) to do so electronically, by going to a secure website, completing and submitting an application to CMS. CMS will reply directly to the entity on its specific obligations and timelines. CMS may require periodic reports, but no more frequently than quarterly.
4. **Records Retention.** Since the information is used for Medicare Secondary Payer matters, CMS may require entities to retain the relevant records for up to 10 years.
5. **Penalties.** CMS may assess a penalty of \$1,000 per day of non-compliance for each individual for which information should have been submitted and was not. Additionally, all Medicare Secondary Payer penalties will apply.

Action Plan

1. If you self-administer a self-funded plan and you have 20 or more employees (whether part-time or full-time) you will need to review the reporting regulations when issued and determine what data you will need to collect.
2. If your plans are insured or administered by a TPA, we recommend that you do the following:
 - a. Upon consultation with the insurer or TPA, determine what data elements are missing;
 - b. Assign responsibility for collecting and delivering the missing data to the reporting entity.
3. If you have an existing administrative service agreement at the present time, review and modify the agreement to reflect the responsibilities of the parties for meeting these new reporting requirements.
4. Seek the assistance of your benefits advisors as needed, to avoid the potentially severe penalties for non-compliance.

We will keep you advised of further developments including the publication of the regulations for MMSEA. For a copy of the full Supporting Statement you may go to: <http://www.cms.hhs.gov/MandatoryInsRep/>

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Attachment C – GHP Data Elements

INSURER GHP DATA SHARING INPUT FILE

Required Data Elements

1. HIC number (HICN; Medicare ID Number)
2. Beneficiary SSN (Required if HICN Not Available)
3. Beneficiary surname (First five letters required)
4. Beneficiary First Initial
5. Beneficiary Date of Birth
6. Beneficiary Sex Code
7. Document Control Number (Assigned by the insurer)
8. Transaction Type (Add, Delete or Update)
9. Coverage Type (Type of insurance coverage)
10. Effective Date (Effective date of current coverage)
11. Termination Date (Termination date of current coverage)
12. Relationship Code (Relationship to policy holder)
13. Policy Holder's First Name
14. Policy Holder's Last Name
15. Policy Holder's Social Security Number
16. Employer Size
17. Small Employer MSP Exception
18. Group Policy Number
19. Individual Policy Number
20. Employee Coverage Election (Who the policy covers)
21. Employee Status (Reason why GHP is primary)
22. Employer EIN and Business Address
23. Insurer EIN and Business Address

Additional Data Elements - Optional

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| 24. Rx Insured ID Number | } | These are the "Four Rx" elements needed for reporting prescription drug coverage. |
| 25. Rx Group Number | | |
| 26. Rx PCN | | |
| 27. Rx BIN Number | | |
| 28. Rx Toll Free Number (To call with questions regarding Rx coverage) | | |
| 29. Person Code (Assigned by Insurer) | | |