

MEDICARE SECONDARY PAYER (MSP) RULES HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN SPONSOR INSTRUCTIONS

Insurers, TPAs, Plan Administrators, and Fiduciaries are required to gather the dependent information related to HRA participation. This is mandatory and will be necessary to begin reporting to the Center of Medicare and Medicaid Services (“CMS”) in the 4th quarter of 2010.

Note: The individuals for whom administrators must report the data elements extend beyond those who are actually entitled to Medicare. Medicare Information is intended to help CMS identify who is entitled to Medicare so the scope of the information required to be reported is much broader.

A TPA is defined for reporting purposes as “an entity that pays and/or adjudicates claims and may perform other administrative services on behalf of (group health plans)..., the plan sponsor(s) or the plan insurer.” TPAs may perform these services for self-insured health plans and will be the responsible party for reporting.

Note: If a group health plan is self administered (employer adjudicates claims and reimburses employees directly from general assets) by the employer, then the employer/plan sponsor is the responsible party for reporting.

Question: Do the MSP reporting requirements apply to Health Reimbursement Arrangement (HRA) plan?

Answer: The MSP reporting requirements will apply to HRAs beginning with the fourth quarter of 2010.

The MSP rules specify when a group health plan must pay primary and when it may pay secondary if an individual is covered under both a group health plan and Medicare. The rules also provide that employers may not offer individuals entitled to Medicare any financial or other incentives to opt out of employer-provided group health coverage, and they prohibit certain actions that "take into account" an individual's Medicare entitlement.

Responsible reporting entities(RREs) (which include insurers, TPAs, plan administrators, and fiduciaries) will be required to cover HRAs in MSP reporting beginning with files submitted in the fourth quarter of 2010 (October-December 2010). The delayed compliance date was intended to give additional time to gather the necessary information to report on HRA coverage. CMS has indicated that it will provide further instructions on reporting HRA coverage at a later date.

Much of the information that has to be reported to CMS is not commonly collected for HRAs. For example, few HRAs collect Social Security Numbers (SSNs) or other specific information about employees' spouses or other family members. **Under the current MSP reporting rules as they apply to group health plans generally, a group health plan must provide CMS with specific information, including SSNs, for all "active covered individuals." In general, an active covered individual is someone who may be Medicare eligible and currently is employed, or the employee's spouse or other family member who is covered by the employee's group health plan and who may be eligible for Medicare. Various age and other requirements also apply.**

TPAs (or Employers self administering HRAs) must begin transmitting eligibility details about HRA participants that will include (but not limited to) the names and social security numbers of spouses and dependents covered under HRA arrangements. This information will be gathered as HRA plans come up for renewal.

There are significant penalties for failure to comply with the MSP reporting requirements. RREs that fail to comply are subject to a civil monetary penalty of \$1,000 for each day of noncompliance for each individual for whom information should have been submitted to CMS. This penalty is in addition to any other penalties prescribed by law and any potential claims under the MSP regulations (e.g., a claim by Medicare that the group health plan should have paid primary to Medicare).

Exceptions for Certain Small Employers

Caution: The small employer exceptions in the MSP statute are based on the **number of employees that the employer has**, not on the number of employees who are enrolled or eligible to enroll in the group health plan.

The prohibition against taking into account Medicare entitlement based on age applies only to group health plans of employers with 20 or more employees for each working day in at least 20 weeks in either the current or the preceding calendar year. (Special rules apply to multiemployer and multiple employer group health plans.)

The 20 employee test must be run at the time the individual receives the services for which Medicare benefits are claimed, thus this requires constant monitoring by employers that have workforces that are close to the threshold. If the employer exceeds the threshold at the relevant time, then the MSP requirements apply to the group health plan, even if fewer than 20 employees participate in the plan.

Counting Employees for the Small Employer Exception (SEE)

For purposes of counting employees, the following rules apply:

- Leased employees must be counted if they would be counted as employees under Code § 414(n)
- All of the employees of the members of an “affiliated service group” (as defined in Code § 414(m) must be counted as if they were employees of a single employer; and
- All of the employers that are considered to be a “single employer” under Code § 52(a) or 52(b) must be treated as a single employer.

Note: The definition of “controlled group” under both Code §§ 52 and §§ 414 relies on the definition in Code § 1563(a), except that for Code § 52(a) purposes, the 80% threshold in Code § 1563(a)(1) is reduced to 50%. In addition, for purposes of Code § 52(a), Code § 1563(a)(4) (involving certain insurance companies) and Code 1563(e)(3)(C) (involving stock owned by the employees’ trust) are not applicable. The overall effect of applying Code §52 is that a larger number of affiliated businesses will be controlled group members under Code §52 than under Code § 414.

Exception to Disability-Based MSP Rules (except End Stage Renal Disease (ESRD)) for Employers with Less than 100 Employees

The prohibition against taking into account Medicare entitlement based on a disability applies only to plans that are “large group health plans.” A plan is a “large group health plan” if the employer “normally employed at least 100 employees on a typical business day during the previous calendar year”. (There are special rules for multiemployer plans and multiple employer plans.) This means that the employer must have 100 or more

employees, whether full-time or part-time, on at least 50% of its regular business days during the previous calendar year.

Note: This exception **DOES NOT** apply to ESRD-based Medicare, for which there is no exception.

“Group Health Plan” defined...

The MSP statute defines a group health plan as “a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provided health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.”

Current Employment Status

The MSP rules generally apply to individuals in “**current employment status**” and their spouses and family members. An individual has current employment status if he or she is actively working as an employee, is the employer (as in the case of an individual who is self-employed), or is associated with the employer in a business relationship. The intention by CMS is cast the broadest possible net.

An otherwise covered individual who is not actively working is considered to be in “current employment status” under the MSP rules if he or she is (a) receiving disability benefits from an employer for up to six months; or (b) retains employment rights in the industry, has not had his or her employment terminated by the employer, is not receiving disability benefits from an employer for more than six months or from Social Security, and has group health coverage other than COBRA coverage (whether or not the individual receives pay). Several other special situations set forth in the MSP regulations may also result in current employment status.

Who are active covered individuals?

“**Active covered individuals**” are defined by CMS as follows:

- All individuals covered in a group health plan who effective January 1, 2009 through December 31, 2010, are ages that are age 55 through age 64 who have coverage based on their own or a family member’s current employment status (effective January 1, 2011, age 55 will be reduced to age 45).
- All individuals covered in a group health plan age 65 and older that have coverage based upon their own or a spouse’s current employment status.
- All individuals covered in a group health plan that have been receiving kidney dialysis or who have received a kidney transplant, regardless of their own or a family member’s current employment status.
- All individuals covered in a group health plan who are under age 55 (effective January 1, 2011, age 55 will be reduced to age 45), are known to be entitled to Medicare, and have coverage in the plan based upon their own or a family member’s current employment status.
- When reporting on these under age 45 individuals, RREs must submit their Medicare Health Insurance Claim Number (HICN).

CMS recommends that third party administrators maintain MSP information for 10 years.

What information must be reported to CMS?

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 should be secondary payer. RRE (Responsible Reporting Entities) must submit the following information for all subscribers, spouses and other family members who are active covered individuals and whose initial date of coverage is January 1, 2009 or later in their initial file submission and all subsequent submissions:

- Social Security Numbers (SSN) or Medicare Numbers (HICN);
- Names of spouses and dependents;
- Birthdates for all subscribers, spouses and other family members that are active covered individuals;
- Gender of subscribers, spouses and other family members that are active covered individuals;
- Relationship code to identify whether active covered individual is a spouse, child or domestic partner;
- Identify if any active covered individuals have ever received a kidney transplant or is currently receiving kidney dialysis.

CMS HICN/SSN Form for Mandatory Reporting

Do RREs have to provide CMS with Health Insurance Claim Numbers (HICNs) or Social Security Numbers(SSNs)?

Yes, to determine whether an individual is a Medicare Beneficiary, the COBC must match an RRE's data to Medicare's data.

What if you have trouble getting HICN/SSNs from Individuals?

In June 2008, CMS issued detailed guidance (enclosed for reference) about the importance of collecting SSNs, Medicare HICNs, and Employer Identification Numbers (EIN) in order to comply with the mandatory reporting requirements. This was created to help employers educate participants and their family members about the legal reasons why this information is needed.

MMSEA 111 - HICN/SSN Collection - GHP Model Language Form (Aug. 18, 2009)

For a copy: <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/RevisedHICNSSNForm081809.pdf>

In May 2009, CMS issued compliance guidance and model language to assist responsible reporting entities (RREs) in obtaining Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN) information from Medicare beneficiaries for mandatory reporting purposes.

The model language prompts individuals to provide HICN or SSN information, but also provides a space for them to explain their refusal to provide the information below their acknowledgment that noncompliant Medicare beneficiaries may be in violation of the MSP rules. Under a safe harbor, if an individual refuses to furnish a HICN or SSN, and the RRE uses the optional model language, the RRE will be compliant for its next file submission to CMS if it (1) obtains a signed copy from the individual of the model language in the format provided, (2) has the model language (with the picture of the Medicare ID card) re-signed and dated at least once every 12 months, and (3) retains the documentation.