

The New Mandatory Medicare Secondary Payer Reporting Rules: What Administrators of Multiemployer and Multiple Employer Group Health Plans Need to Know

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Administrators of self-insured multiemployer and multiple employer plans face new mandatory quarterly reporting requirements for group health plans that cover Medicare-eligible individuals. This article explains the requirements—including registering during the month of April 2009 with the Centers for Medicare and Medicaid Services coordination of benefits contractor—and discusses challenges plans may face in complying with the new reporting process.

The Medicare, Medicaid and SCHIP Extension Act of 2007¹ amended the Medicare secondary payer rules to impose new mandatory quarterly reporting requirements on group health plans² that cover Medicare-eligible individuals. The requirements are intended to make it easier for Medicare to identify instances in which a group health plan should be paying primary to Medicare.

The reporting responsibility—and the exposure to potential penalties—falls on what the Centers for Medicare and Medicaid Services (CMS) calls *responsible reporting entities* or RREs. There are three types of RREs: (1) insurers of group health plans, (2) third-party administrators of group health plans and (3) plan administrators or fiduciaries of group health plans that are both *self-insured* and *self-administered*. Thus, plan administrators of self-insured multiemployer plans or multiple employer plans are RREs and need to comply with the new requirements.

This article provides an overview of the new requirements and the reporting process.

It discusses challenges that multiemployer and multiple employer group health plans that are RREs will face in attempting to comply. It is not intended to be a how-to guide. The CMS GHP User Guide and other materials posted on the CMS Web site, www.cms.hhs.gov/MandatoryInsRep,³ provide more detailed information about the reporting process.

Overview of Medicare Secondary Payer Rules⁴

Medicare secondary payer (MSP) rules govern how group health plans coordinate payment of hospital and medical claims with Medicare. A plan generally is required to pay before (i.e., primary to) Medicare for claims incurred by:

- Individuals aged 65 and older (employees and/or their covered spouses) who have group health plan coverage on the basis of current employment status if the plan sponsor employed 20 or more W-2 full- and part-time employees each

working day in at least 20 weeks during the current or prior calendar year

- Individuals under the age of 65 (employees and/or their covered dependents) who are disabled and have group health plan coverage on the basis of current employment status if the employer sponsoring the group health plan employed 100 or more W-2 full- and part-time employees on at least 50% of the business days of the prior calendar year
- Individuals with end-stage renal disease regardless of age or employer size during the first 30 months of Medicare entitlement.

Special rules apply to multiemployer and multiple employer plans. Generally, if even one participating employer in a multiemployer or multiple employer group health plan has 20 or more full- or part-time employees, the plan must pay primary to Medicare for *all* individuals covered by the plan who are entitled to Medicare on the basis of age. This applies

to even those who are associated with an employer with fewer than 20 employees. A multiemployer or multiple employer group health plan may request that CMS approve a small employer exception (SEE) with respect to individuals associated with a participating employer that has fewer than 20 employees. If the SEE is approved, Medicare will pay primary for those individuals only.

A similar rule applies to individuals who have coverage on the basis of disability. If even one participating employer has 100 or more full- or part-time employees, the group health plan must pay primary to Medicare for *all* individuals covered by the plan who are entitled to Medicare on the basis of disability. However, there is no SEE available in this situation. There is no employer-size exception for individuals who are entitled to Medicare on the basis of end-stage renal disease.

Current Employment Status

As previously discussed, where Medicare entitlement is based on age or disability, a group health plan is required to pay primary to Medicare only with respect to individuals who have coverage on the basis of current employment status. Thus, a group health plan would pay primary for an active employee or the spouse of an active employee who is entitled to Medicare on the basis of age, but would pay secondary to Medicare with respect to claims of retirees or their spouses. While active employees clearly have coverage on the basis of current employment status, individuals who are not actively at work may still be considered to have coverage on the basis of current employment status if they are not actively working but they:

- Are receiving disability benefits from an employer that are subject to FICA taxes, or
- Have retained employment rights in the industry and have not had their employment terminated by the employer (if the employer provides the coverage) or have not had their membership in the employee organization terminated (if the employee organization provides the coverage) and meet certain other conditions. Individuals who are considered to have retained employment rights include:

- Persons who are furloughed, temporarily laid off or on sick leave
- Seasonal workers who normally do not work throughout the year
- Persons who have health coverage that extends beyond or between active employment periods; for example, based on an hours bank arrangement.

Current employment status is derivative; the covered spouse or family member of an employee who has coverage on the basis of current employment status will also have coverage on that basis.

Penalties for Noncompliance

A group health plan that pays secondary to Medicare when it should have paid primary under the MSP rules faces significant penalties. Not only may the federal government recover double damages for claims that Medicare incorrectly paid out as primary, but the law provides for double damages for private causes of action, as well. An employer or employee organization that contributed to the group health plan may also be subject to an excise tax of 25% of its expenses incurred during the calendar year.⁵

The Group Health Plan Reporting Process

Overview

The mandatory reporting program involves an electronic exchange of group health plan coverage/Medicare entitlement information between an RRE and the CMS coordination of benefits contractor (COBC). An RRE is required to submit an MSP input file quarterly for each employee and dependent whom it has identified as an “active covered individual.” To identify individuals who are Medicare beneficiaries, the COBC will match the data submitted on the MSP input file with data from the Social Security Administration. Then the COBC will update the Medicare systems and databases used by Medicare contractors to pay claims to indicate whether Medicare should be paying primary or secondary. It will also provide the RRE with Medicare Part A entitlement and Medicare Part B enrollment information for individuals covered by the group health plan who have been identified as Medicare beneficiaries.

In addition to submitting an MSP input file for active covered individuals, an

RRE also may exchange information about an individual’s prescription drug coverage with the COBC. This may include information about individuals for whom Medicare would pay primary. Under this expanded reporting option, COBC will provide the RRE with information about an individual’s Medicare Part D enrollment in addition to information about Medicare Part A entitlement and Medicare Part B enrollment. RREs that are participating in the retiree drug subsidy (RDS) may use this reporting option to submit retiree files to the RDS center.

The Registration Process

An RRE that did not have an existing agreement to provide coverage information to CMS under a voluntary data-sharing program must register on the COB Secure Web site (COBSW) between April 1 and 30, 2009. CMS will post details at www.cms.hhs.gov/MandatoryInsRep on how to complete the registration process on the COBSW.

Although an RRE may contract with an agent to exchange data with the COBC, the actual registration must be submitted by an authorized RRE representative; an agent cannot complete this on the RRE’s behalf. The RRE will be required to assign an account manager who will serve as the administrative contact for the RRE and control the overall account. To ensure that the data exchange process is working properly, there will be a testing period prior to the date of the initial file submission.

File Submission Time Frames

An RRE must submit its MSP input files in each calendar quarter during an assigned seven-day file submission time frame. An RRE’s initial submission time frame will be sometime during the third quarter (July-September) of 2009.

MSP Input File Data Requirements

The MSP input file is designed to elicit the information that will enable the COBC to determine when Medicare should be paying secondary for a group health plan enrollee.

Active Covered Individuals

To help identify individuals for whom Medicare should be paying secondary,

CMS has developed the concept of an active covered individual—someone enrolled in the group health plan for whom Medicare would likely pay secondary under the MSP rules described above if employer size is disregarded.

For this purpose, an *active covered individual* is

- Any individual aged 65 or older who has coverage based upon his or her own or a spouse's current employment status
- For the period beginning January 1, 2009 and ending December 31, 2010, any individual between the ages of 55 and 64 who has group health plan coverage based on his or her own or a family member's current employment status. Effective January 1, 2011, the age threshold is lowered to 45.
- Any individual covered by the group health plan who has been receiving kidney dialysis or who has received a kidney transplant, regardless of his or her own or a family member's current employment status
- Any individual younger than age 55 (age 45, effective January 1, 2011) who is known to be entitled to Medicare and who has group health plan coverage based on his or her own or a family member's current employment status.

An RRE generally will have to submit a record for each active covered individual. The initial MSP input file submission must contain records for all active covered individuals who had group health plan coverage that was in effect on or after January 1, 2009, even if that coverage terminated before the submission date. Subsequent quarterly update files generally must include records for any active covered individual who became covered since the last file submission.

Record Matching Criteria

To determine whether an active covered individual is a Medicare beneficiary, the COBC must match its data to Medicare's data. Accordingly, an RRE will be required to provide in the MSP input file the following information for each active covered individual:

- The Medicare health insurance claim number (HICN) or Social Security number (SSN)

- The first initial of the first name
- The first six characters of the last name
- Date of birth
- Gender.

The COBC must have an exact match on the SSN or HICN, and at least three of the remaining criteria must be matched exactly. If a match is found, an RRE will be provided the correct HICN to use going forward.

Beginning with its initial file submission, an RRE will be required to submit the SSN or HICN of each active covered individual who is an employee. It will also be required to submit the SSN or HICN of each spouse or family member whose group health plan coverage first became effective on and after January 1, 2009. However, an RRE has until its file submission for the first quarter (January-March) of 2011 to submit records with the SSNs or HICNs for spouses and other family members who are active covered individuals and whose initial date of group health plan coverage was prior to January 1, 2009.

Information About Employer Size and SEEs

As discussed in the overview of the MSP rules, employer size is critical to determining whether Medicare will be the primary or secondary payer when Medicare eligibility is based on age or disability. An RRE generally will be required to report the number of employees employed by the employer through whose group health plan a specific active covered individual has coverage. An actual employee count is not required; rather, the RRE will have to indicate which size range—0-19 employees, 20-99 employees, or 100 or more employees—applies. An RRE of a multiemployer or multiple employer plan will be required to report the employer size of the largest employer in the plan. Employer size must be calculated once each calendar year.

As discussed, a multiemployer or multiple employer group health plan that must pay primary to Medicare because a participating employer employs at least 20 employees may request a SEE with respect to a participating employer with fewer than 20 employees. If approved, Medicare will pay primary for active covered individuals who have group health plan coverage through that

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employer. An RRE may indicate on the MSP input file whether a particular active covered individual has coverage through a participating employer that has been granted an SEE.⁶

MSP Response Files From the COBC

The COBC will send an RRE a response file within 45 days of receipt of an MSP input file. The response file will contain a disposition code for each record included in the MSP input file. Certain disposition codes will indicate whether an individual has been identified as a Medicare beneficiary and, if so, whether Medicare will pay primary or secondary. Other disposition codes will indicate whether there are errors that the RRE must correct in its next submission. The response files may also contain updated information from the COBC regarding an individual's SSN, HICNs, name, birth date, etc., that the RRE should then use to correct its records.

Penalties for Failure to Report

An RRE may be fined up to \$1,000 per day for each individual for whom information should have been reported to the COBC. This is in addition to any penalties that may be imposed if a group health plan pays secondary to Medicare when it should have paid primary under the Medicare secondary payer rules.

Action Plan for Multiemployer and Multiple Employer Plan RREs

With the registration deadline approaching, an RRE for a multiemployer or multiple employer plan should take the following actions.

Item 1. Obtain information about the size of each participating employer.

As discussed above, an RRE will be required to provide information regarding the size of the largest employer participating in a multiemployer or multiple employer group health plan. While it may be able to ascertain the number of plan participants associated with a particular employer, it may not have the information regarding the number of individuals employed by that employer that it needs to determine the size of the largest employer under the standards described

above. Without this information, it could potentially underreport the employer size, which could mean that Medicare would improperly pay primary for all plan participants, when it should be paying secondary.

In addition, without accurate information about employer size, the RRE would not be able to obtain an SEE, which would appropriately shift primary payment responsibility to Medicare for certain individuals whose coverage is through a participating employer with fewer than 20 employees. A request for an SEE should be made before the first initial submission to ensure that Medicare is properly designated as the primary payer.

Item 2. Obtain information to determine which individuals have coverage on the basis of current employment status or are otherwise considered to be active covered individuals.

CMS officials have stated that any individual whose information is submitted to Medicare under the mandatory MSP reporting program will be considered to be an active covered individual for whom the group health plan would most likely pay primary.

This means that an RRE cannot simply report to CMS all individuals covered by the plan who are aged 55 or older. To be certain that Medicare pays primary when appropriate (e.g., for retirees and their dependents), it will need to be able to distinguish between those individuals (both employees and their dependents) who have coverage on the basis of current employment status and those who do not.

In addition, an RRE will have to make certain it receives all of the information it needs from participating employers to be able to determine current employment status and to identify all individuals with dependent coverage who qualify as active covered individuals.

Item 3. Obtain the required information about each individual who is being reported to CMS.

Although the plan administrator may already have much of the required information for employees (or can obtain SSNs from a participating employer), it may not have SSNs, birth dates or other

information for the employee's family members who are active covered individuals. It will have to obtain the SSNs for all covered family members (and not just the employee/participant) who first become covered under the plan on or after January 1, 2009 in their initial submission.

Item 4. Evaluate whether its system will be able to conduct the data exchange with the COBC and, if so, develop procedures for processing the COBC MSP response file.

Because the exchange of data is conducted electronically, the systems utilized by an RRE must be adequate for transmitting and receiving files from the COBC. It must also have sufficient capacity for storing files. In addition, an RRE will have to develop procedures for processing the COBC MSP response files. If it determines that its system is inadequate, it should act now to find an agent that can handle these files on its behalf.

Item 5. Determine whether it wants to utilize the enhanced reporting option.

RREs of plans that provide for retiree coverage may want to utilize the enhanced reporting option to find out whether a retiree is enrolled in Medicare, including Medicare Part D. Because retirees do not have coverage on the basis of current employment status, Medicare should be the primary payer for these individuals and their spouses.

Summary

The new mandatory reporting requirements pose unique challenges for plan administrators of self-funded multiemployer and multiple employer plans. To ensure that their plans will be able to comply with the new rules and avoid penalties, they should begin immediately to initiate the action plan described in this article. Most importantly, they need to register with the COBC during the April 2009 registration period. **B&C**

Endnotes

1. PL 110-173, Section 111.
2. The new requirements apply to group health plans that provide hospital and medical coverage, including health reimbursement accounts that reimburse those types of expenses. Dental plans, health flexible spending accounts

and health savings accounts are not subject to the rules.

3. Much of the information in this article is based on information contained in the GHP User Guide Version 2.0 that was issued by CMS on December 17, 2008. The guide and other material may be found on the CMS Web site at www.cms.hhs.gov/MandatoryInsRep.

4. 42 USC 1395y(b)(7).

5. 42 USC 1395y(b)(2)(B)(iii); 42 USC 1395y(b)(3)(A) and (B).

6. More information about the small employer exception may be found at www.cms.hhs.gov/MandatoryInsRep/Downloads/GHPSEALERT010909.pdf.



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