

**Welfare Benefits 2008 Year in Review:
Medicare Secondary Payer Mandatory Reporting**

2009 brings with it a great deal of legislation that was passed in 2008, including the new requirement that traditional group health plans, Taft-Hartley plans and Multi-Employer Welfare Arrangements begin collecting and reporting Medicare Secondary Payer (“MSP”) data to the Centers for Medicare and Medicaid Services (“CMS”). The new reporting requirements were passed by Congress under the Medicare, Medicaid, and SCHIP Extension Act of 2007 (“MMSEA”), which was signed into law in 2008. Subject to CMS’s future regulations, certain prescribed data elements must be reported to CMS on a quarterly basis. The penalty for failing to report the required data elements is \$1,000 per day per person for which the date it should have been submitted.

Background

The MMSEA requires health insurers, third-party administrators (“TPAs”), and self-funded plan fiduciaries to submit to CMS identifying situations where the group health plan may be secondary to Medicare. This mandatory reporting requirement is the latest attempt by Congress to ensure proper coordination of benefits between Medicare and group health plans, and thus to ensure the continued financial viability of the Medicare system. Section 111 of the MMSEA establishes separate mandatory reporting requirements for group health plans, liability insurance programs, no-fault insurance, and workers compensation programs. The effective date for reporting group health plan data was January 1, 2009, whereas the effective date for all other programs is July 1, 2009.

The Reporting Process

For fully insured plans the reporting requirement (and thus the penalty for failing to report) falls on the insurer. For self-insured plans that use a TPA to administer claims, the burden falls on the

TPA. For self-insured plans that pay their own claims, the duty belongs to the fiduciaries of that plan.

Many of the larger insurers already report MSP information to CMS on a quarterly basis. CMS estimates that for 70% of participants in fully insured plans at least some information is currently being reported. For these plans, the burden of complying with MSP mandatory reporting is minimal.

For the 30% of participants in fully insured plans for whom their data is not currently reported, new information gathering processes and policies must be created, and an interface with CMS must be established. The level of detail of data elements required to be reported is quite extensive, and so your plan’s participants may be subjected to additional inquiries from your insurer. In an effort to prepare your plan, we set forth on the second page of this update the required and optional data elements that your insurer may collect from your members and their families.

Effect on Plan Sponsor

The effect of the new MSP law differs depending on what type of health and welfare plan you have. If you are an insured plan, or a self-insured plan that uses a TPA, your insurer or TPA will need to implement internal policies and adequate procedures to identify, collect, and submit data on all Medicare-eligible participants and to make the appropriate benefit determinations. The data collection will likely require a cooperative process between the plan fiduciaries and the insurer or TPA.

Our recommendation is two-fold: First, the employer (or trustees of a Taft-Hartley plan) should inquire of your insurer or TPA to determine what, if any, additional information will need to be collected. Then find out what are the insurer’s plans to collect that information. Second, many insur-

ance contracts provide that premiums may be increased with a change in the law. The insurance contract should be reviewed to determine the extent to which the insurer may rightfully take this course of action, and the insurer should be questioned about whether or not it will do so. For plans that use a TPA, many TPA contracts contain similar language that transfers the expense and risk of non-compliance to the employer/plan sponsor, so your administrative services agreement should be reviewed and a dialogue begun with your TPA to discuss the cost and responsibility for data collection and reporting, and to ensure that the responsibility for the process is clearly stated in an amendment to the administrative services agreement.

If you are a self-funded plan that administers its own claims, the new MSP rules apply directly to your plan, but fortunately the effective date has been delayed by CMS. According to guidance published in the Federal Register by DHHS, self-funded plans must register online with CMS's MSP information technology contractor by April 30, 2009. The contractor will work with the plan to prepare the proper interface and data packaging software for electronic submission of the required data elements. The first package of information should be sent by July, after which CMS's contractor and the plan will work out any kinks. CMS wants all plans to be quarterly submitting information by October of 2009.

Despite the delayed effective date, self-funded, self-administered plans should immediately begin implementing policies and procedures to identify, collect, and submit the required data elements on all Medicare-eligible participants and to make the appropriate benefit determinations.

Required Data Elements:

1. HIC number (HICN; Medicare ID Number)
2. Beneficiary SSN (required if HICN is 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 upgrade)
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

Optional Data Elements:

1. Rx Insured ID Number
2. Rx Group Number
3. Rx PCN
4. Rx BIN Number
5. Rx Toll Free Number (to call with questions regarding RX coverage)
6. Person Code (assigned by insurer)

For more information, or to begin the process briefly outlined herein, please contact us at your earliest convenience.

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