Alert: Medicare, Medicaid, and SCHIP Extension Act of 2007 Creates Mandatory Reporting Requirements for Group Health Plans And Insurers

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The Medicare, Medicaid, and SCHIP Extension Act of 2007 (“MMSEA”) instituted a new mandatory reporting law that requires Responsible Reporting Entities or "RREs" to report specified information regarding group health plan arrangements (“GHPs”) to CMS. The law also imposes this same requirement on liability insurers (including self-insurers), no-fault insurers and workers’ compensation insurers. RREs can include group health plan insurers, third party administrators, and plan administrators or fiduciaries of self-insured/self-administered group health plans. The purpose of the new law is to provide the Centers for Medicare and Medicaid Services ("CMS") the authority to mandate the reporting of information to assist CMS in determining whether Medicare has primary responsibility for paying the medical expenses of a Medicare beneficiary. RREs that do not comply with CMS’ reporting requirements will face penalties.

Each RRE must register with CMS’ Coordination of Benefits Contractor (“COBC”) to provide CMS with notice of its intent to report data in compliance with the requirements of the MMSEA. The majority of GHP RREs must register between April 1, 2009 and April 30, 2009. RREs for liability insurance (including self-insurance), no-fault insurance, and workers’ compensation, will register from May 1, 2009 through June 30, 2009. Once a registration application is submitted, the COBC will work with the RRE to set up the data reporting and response processes.

In keeping with the purpose of the new law, GHP RREs must report information to CMS on “active covered individuals” which are those individuals who may be Medicare eligible and are currently employed, or are the spouse or other family member of a worker who is covered by the employed individual’s GHP and who may be eligible for Medicare. CMS requires the RRE to include all of the individuals covered by the GHP for whom, if they had Medicare, Medicare would be a secondary payer. The COBC will then determine if the active covered individual is a Medicare beneficiary and whether Medicare is the primary or secondary payer.