CMS Release Updates HRA Coverage Reporting

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On June 25, 2010, the Centers for Medicare and Medicaid Services (CMS) released an updated Group Health Plan User Guide related to the Medicare Secondary Payer Mandatory Reporting requirements applicable to group health plans. The new rules dictate when a group plan must pay claims as the "primary insured" for an employee or the employee's spouse or eligible dependent if that individual is covered by both the plan and Medicare.

Among the issues addressed in the updated guide are references to changes in reporting for Health Reimbursement Arrangements (HRAs). CMS has removed all references from the updated guide that previously referred to reporting only for "free-standing" HRAs. Prior versions of the guide also referenced "imbedded coverage" as HRA coverage that was part of a more comprehensive or standard group health plan that need not be separately reported.

What does this mean for group health plans going forward? It means that all HRA coverage must now be reported by the "responsible reporting entity" (RRE) if it otherwise meets the reporting requirements, regardless of whether the HRA is considered to be "imbedded" or "freestanding" coverage. If a group plan provides both standard coverage and HRA coverage, then the RRE may need to submit two records to CMS – one for the standard coverage and one for the HRA coverage.

Note that RREs are not required to report HRA coverage retroactively. Instead, HRA coverage must only be reported for coverage effective on or after October 1, 2010. In addition, the guide stipulates that only HRA coverage which reflects an annual benefit value of $1,000 or more is to be reported. Therefore, HRA coverage with an annual benefit amount that totals less than $1,000 will be exempt.

Please contact a member of the Employee Benefits Practice Group if you have questions regarding the new reporting obligations applicable to HRAs.