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Group Health Plan Disclosure and Reporting Requirements

Creditable/Non-creditable Prescription Drug Required Disclosures

The Medicare Modernization Act (MMA) requires entities, including employer sponsored group health plans, whose coverage includes prescription drugs, to notify Medicare-eligible individuals and the Centers for Medicare and Medicaid Services (CMS) about whether or not their prescription drug coverage is "creditable coverage." "Creditable coverage" is coverage that is expected to pay on average at least as much as the standard Medicare prescription drug coverage. For these entities, there are two disclosure requirements.

The first disclosure requirement is to provide a written notice of creditable or non-creditable coverage status annually to all Medicare-eligible individuals who are covered under an entity's prescription drug plan. The notice must be provided prior to October 15th each year and at various times as stated in the regulations, including when a Medicare-eligible individual joins the plan. This disclosure must be provided to Medicare-eligible actively working individuals and their dependents, Medicare-eligible COBRA individuals and their dependents, Medicare-eligible disabled individuals covered under a prescription drug plan, and any retirees and their dependents. The MMA imposes a late enrollment penalty on individuals who do not have creditable coverage for a period of 63 days or longer following their initial enrollment period for the Medicare prescription drug benefit. Accordingly, this information is essential to an individual's decision whether to enroll in a Medicare Part D prescription drug plan.

The second disclosure requirement is for entities to complete the "Online Disclosure to CMS Form" to report the creditable or non-creditable coverage status of their prescription drug plan to the CMS. The disclosure must be completed annually no later than 60 days from the beginning of a plan year (contract year, renewal year), within 30 days after termination of a prescription drug plan, or within 30 days after any change in creditable coverage status. *(Note: This requirement does not apply to the Medicare beneficiaries for whom entities are receiving the Retiree Drug Subsidy (RDS) because disclosure to CMS is part of the RDS process.)*

The CMS online disclosure form is available at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

More guidance, along with model certificates for creditable and non-creditable drug coverage, is available on the CMS website at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index.html?redirect=/CreditableCoverage/01_Overview.asp

GBS has created FAQs to assist employers in preparing Part D certificates

Reporting

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and Section 4002 of the SUPPORT for Patients and Communities Act (Support Act) added mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan (GHP) arrangements. The purpose of MMSEA reporting is to enable Medicare to correctly pay for the health insurance benefits of Medicare beneficiaries by determining primary versus secondary payer responsibility. MMSEA rules specify who must report to CMS – called a Responsible Reporting Entity (RRE), what must be reported, and the form and manner that must be used for reporting. The RRE is the entity serving as an insurer or third party administrator for a group health plan. In the case of a group health plan that is self-insured and self-administered, the plan administrator or fiduciary is the RRE. RREs may use agents to submit data on their behalf, but an RRE remains solely responsible and accountable for adhering to the reporting requirements and for the accuracy of the data submitted. On a quarterly basis, an RRE must submit a file of information about employees and dependents who are Medicare beneficiaries with employer group health plan coverage that may be primary to Medicare.

RREs are required to report primary prescription drug coverage of Medicare beneficiaries. Insurers and third party administrators that provide prescription coverage to GHPs are responsible for reporting to CMS. For employers that have a prescription drug carve-out with a pharmacy benefit manager (PBM), the PBM is considered the RRE. If, however, an employer's prescription drug coverage is self-insured and self-administered, then the plan administrator or fiduciary is the RRE. So, an employer will very rarely be the RRE for these purposes.

Medicare authorizes a per day penalty for failing to comply with the MSP reporting requirements. The indexed penalty is $1,325 beginning on March 17, 2022.

More information, including a user guide for RREs, is available on the CMS website at:

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html

https://www.cms.gov/files/document/group-health-plan-ghp-reporting-substance-use-disorder-prevention-promotes-opioid-recovery-and-2

The intent of this analysis is to provide general information regarding the provisions of current federal laws and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.