Kilpatrick

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Group Health Plan Section 111 Reporting is Back

Self-insured plan sponsors thought they had seen the last of Group Health Plan Section 111 Reporting in 2009, but like a character in a movie …… it's baaaccckkk.

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 added mandatory reporting requirements with respect to (1) Medicare beneficiaries who have coverage under group health plan arrangements, and (2) Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation. Implementation of these reporting requirements occurred in two stages in 2009.

In general, employer group health plans are required to pay primary (and Medicare pays secondary) when the individual (or his/her spouse) has current employment status with the employer and is covered by the group health plan. The mandatory reporting allows Medicare to pay benefits appropriately, so that Medicare does not pay primary when an employer group health plan is required to pay primary.

The entity that is responsible for reporting on behalf of a self-insured group health plan is the plan's third party administrator(s) that pay and/or adjudicate claims. Back in 2009, many TPAs instituted extra fees to cover the costs of the mandatory reporting. At the same time, due to the massive data that was involved in the reporting, many employers had to increase the types of data elements that they were obtaining from their health plan enrollees to facilitate the mandatory reporting. Originally, the mandatory reporting only applied to medical coverage, and the reporting process made it optional to exchange prescription drug coverage information to coordinate benefits related to Medicare Part D.

However, reporting prescription drug coverage information will no longer be optional beginning January 1, 2020. Under Section 4002 of the Support for Patients and Communities Act (adopted in October 2018) reporting entities will be required to report primary prescription drug coverage information beginning in 2020. For self-insured group health plans, this means that the plan's pharmacy benefit manager will likely be required to report, due to its status as a third party administrator. But, like in 2009, plan sponsors should look for messages from their PBMs about this reporting, any associated extra fees to perform the reporting and potential PBM contract amendments. In some cases, additional data feeds may also be necessary to facilitate the reporting requirements.