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CMS Updates Group Health Plan Reporting Concerning HRAs

CMS recently issued an updated version of the Section 111 Mandatory Group Health Plan Reporting Guide. The Guide provides rules on how responsible reporting entities (RREs) must report group health plan coverage to CMS for purposes of the Medicare Secondary Payor requirements.

Previous versions of the Guide noted that health reimbursement arrangements (HRAs) are group health plans that are subject to the mandatory Medicare Secondary Payor reporting requirements. The updated version provides that HRAs include individual coverage HRAs (ICHRAs), regardless of whether the ICHRA can be used to pay premiums and/or medical claims and excepted benefit HRAs. Reportable HRAs also include qualified small employer health reimbursement arrangements (QSEHRAs). The above HRAs are subject to the Medicare Secondary Payor reporting requirements regardless of whether or not they have an end-of-year carry-over or roll-over feature.

Despite the broad reporting requirement above, the updated version of the Guide retains the exemption for small dollar HRAs (below $5,000). As a result, no HRA must be reported if the current year annual benefit is less than $5,000. This amount is measured by the annual benefit of the HRA – not claims paid. The annual benefit includes current year accruals, plus any carryovers. If an HRA accrues additional amounts during the year, reporting for the HRA applies at the next reporting cycle once the HRA reaches or exceeds $5,000. See, Section 7.2.7 of the Guide for additional information.