Health Reimbursement Arrangements

Section 111 Medicare Reporting

Revised July 2011

Effective for plan years beginning on or after Oct.1, 2010, the Centers for Medicare & Medicaid Services (CMS) require certain entities to provide information concerning Health Reimbursement Arrangements (HRAs) using an online reporting system. These same requirements previously applied to group health plans, effective Jan.1, 2009. These requirements were due to enactment of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), which added new mandatory reporting requirements (also known as Section 111 reporting requirements) for group health plans. The information obtained by CMS will be used to determine coordination of benefit responsibilities between Medicare, Medicaid and HRAs.

For the purpose of reporting, a responsible reporting entity (RRE) that is required to report to CMS includes:

- The insurer for a fully insured plan
- The third-party administrator (TPA) for a self-funded plan
- The plan administrator for a self-funded plan that self-administers

Reporting

An RRE that is an HRA-only plan with no additional reporting for any other type of group health plan should have registered with CMS by June 30, 2010. RREs were not required to register with CMS if they have nothing to report. Plans that are reported do not include Health Flexible Spending Accounts, Health Savings Accounts, stand-alone dental, stand-alone vision or prescription drug plans.

Plan years beginning on or after Jan. 1, 2011, began reporting in 2011 on a quarterly basis.

Exceptions:

- Small plans sponsored by employers with fewer than 20 employees need only report those receiving a kidney transplant or kidney dialysis.
- Plans with less than $1,000 annual benefit maximum are exempt.

Previously, guidance issued by CMS stated that “integrated” plans that were imbedded or part of a comprehensive group health plan were also excepted from the reporting requirements. However, a previous version of the guide eliminated that exception. Now, HRA coverage of any kind, freestanding or integrated, must be reported in addition to other, non-HRA group health plan coverage.

Who is Reported?

All group health plans with 20 or more employees (not participants) must report data on the following individuals. The key factor is whether they have participants (covered children, spouses or employees) who are aged 45 or older, on kidney dialysis or had a kidney transplant, or enrolled in Medicare. As a reminder, a group health plan with fewer than 20 employees only has to report the kidney dialysis/transplant individuals.

- Participants who are aged 45 — 64 who have coverage based on active employment (includes the employee and family members)
- Participants who are aged 65 and older who have coverage based on active employment (again, employees and family members)
- Participants who are receiving kidney dialysis or have received a kidney transplant (employees or family members under active group plan, COBRA coverage/or retiree plan)
- Participants under the age of 45 who are known to be entitled to Medicare and have coverage based on active employment (again, employees and family members)

Penalties

Entities that fail to comply with the Section 111 reporting requirements are subject to a civil monetary penalty of $1,000 for each day of noncompliance for each individual for whom information should have been submitted. This fine is in addition to any other penalties prescribed by law and any potential claims under the Medicare Secondary Payer (MSP) regulations, which could include claims paid by Medicare that the group health plan or HRA should have paid primary to Medicare.

Frequently Asked Questions

Q. What is an HRA?

A. Many employers sponsor HRAs and do not realize it. An HRA is an arrangement that:

- Is paid for solely by the employer and not provided pursuant to salary reduction election or otherwise under an Internal Revenue Code (IRC) § 125 cafeteria plan
- Reimburses the employee for medical care expenses (as defined by § 213(d) of the IRC) incurred by the employee and the employee's spouse and dependents (as defined in § 152)
- Provides reimbursements up to a maximum dollar amount for a coverage period (IRS Notice 2002-45)

A plan that is employer-sponsored and employer-funded and that reimburses medical expenses is thus considered an HRA. HRAs are ERISA plans and need to comply with the necessary requirements, including developing a written plan document, filing a Form 5500, satisfying the nondiscrimination rules that prohibit favoring highly compensated employees and offering COBRA.

An example of an HRA plan would be an employer plan with a $2,000 deductible. The employees pay the first $500 of the deductible, but the employer reimburses employees for the remaining $1,500 of the deductible upon proof of medical expenses.

Q. An employer's HRA self-funds a $1,500 annual maximum but uses a TPA to administer the plan. Does the employer need to report?

A. The TPA in this situation would be considered an RRE and is responsible for reporting the required information. However, the employer should still confirm that the TPA is aware of the requirements for plan years beginning on or after Oct. 1, 2010.

Q. An employer's HRA self-funds a $750 annual maximum and administers it in house. Does the employer need to report?

A. Since the employer in this situation is the plan administrator, the employer would be considered the RRE. However, there is an exception for plans with less than a $1,000 maximum. Therefore, this employer would be exempt from the reporting requirements.

Q. Where can I read more and register my HRA?

A. The Section 111 MSP Mandatory Reporting GHP User Guide, last updated on April 20, 2011, can be reviewed at www.cms.gov/MandatoryInsRep/Downloads/GHPUserGuideV3.2.pdf.

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