EMPLOYEE BENEFITS
Willis ALERT
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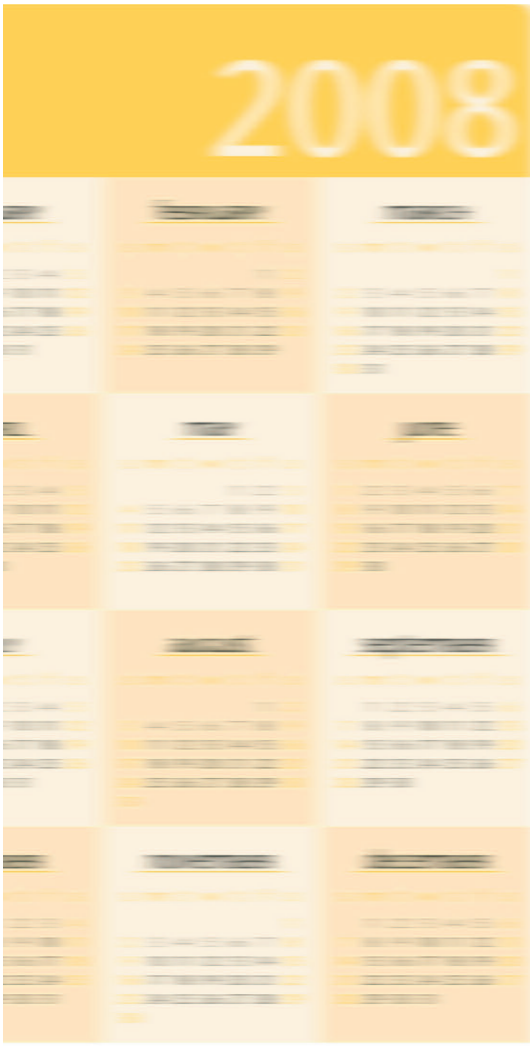
MEDICARE REPORTING OBLIGATIONS, NEW AND OLD

MORE AND MORE, PLAN SPONSORS ARE SUBJECT TO MANDATES RELATED TO MEDICARE, FROM SECONDARY PAYER (MSP) REPORTING RESPONSIBILITIES TO DISCLOSURE REQUIREMENTS IN CONNECTION WITH MEDICARE PART D. WE REVIEW THREE KEY REPORTING OBLIGATIONS: CREDITABLE COVERAGE REPORTING, RDS RECONCILIATION AND REPORTING ON PRIMARY PAYER STATUS.



1. CREDITABLE COVERAGE REPORTING: DEADLINE NEARS

Plan sponsors must disclose to certain plan participants and report to the Centers for Medicare and Medicaid Services (CMS) whether their plans provide creditable or non-creditable prescription drug coverage. For 2008 calendar year plans, the annual reporting deadline is March 1; no extensions are available. In addition to the annual report, sponsors must report during the year any change that affects a plan's creditable prescription drug coverage status. Prescription drug coverage is creditable if it is at least the actuarial equivalent of Medicare's standard prescription drug benefit.

The creditable coverage report provides CMS with the number of plans or benefit options that provide prescription drug coverage, whether that coverage is creditable or non-creditable and how many Part D-eligible individuals are covered. The report also provides information about an employer's compliance with the disclosure requirements. For details on the prescription drug coverage disclosure requirement, see Willis' *Employee Benefits Alert*, Issues **104** and **118**.

REPORTING TIMELINES

The timeframes for reporting are:

- **Within 60 days after the first day of each plan year (March 1 for 2008 calendar-year plans)**
- **Within 30 days after the termination of a prescription drug plan**
- **Within 30 days after any change in the creditable coverage status of prescription drug coverage**

To determine the plan year for prescription drug coverage, refer to the contract or renewal year of your prescription drug program.

WHO MUST FILE?

Sponsors of plans that provide prescription drug coverage to one or more Part D-eligible individuals as of the first day of the plan year must file a creditable coverage report. If there are no Part D-eligible individuals covered by the plan as of the first day of the plan year, the sponsor is not required to file the report that year. Determining which employees and covered dependents are Part D-eligible individuals can be challenging for plan sponsors; CMS recommends working with insurers or third-party administrators to determine how many, if any, Part D-eligible individuals are covered.

In some limited situations, an employer may not be required to file a report with respect to prescription drug coverage provided to retirees. For example, some plan sponsors contract with an outside Part D plan to provide prescription drug coverage for their retirees. Others may even contract with Medicare directly as a Part D plan. For these prescription drug programs, an employer is not required to file a disclosure report. Similarly, a plan sponsor participating in the retiree drug subsidy (RDS) program is also exempt from reporting, but only with respect to those retirees for whom the sponsor is claiming the subsidy.

COMPLETING AND FILING THE REPORT

Plan sponsors file the disclosure reports online. This year, a hard copy of the form can be faxed upon request for entities without online access. The disclosure form is simple and takes only a few minutes to complete if the information is at hand.

Plan sponsors should report separately for each prescription drug benefit option within a plan. A benefit option is a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan. To assist plan sponsors in completing the disclosure form, CMS provides **creditable coverage disclosure guidance, form instructions and screen shots** on its website.

2. RDS RECONCILIATION PROCESS

The RDS program, which began in 2006 when Medicare added its prescription drug benefit, makes payments to plan sponsors that provide equivalent prescription drug coverage to qualifying retirees who do not enroll in Medicare's prescription drug program. During 2007, CMS set forth a 12-step reconciliation process that applies to plan sponsors that enroll in the RDS program and receive subsidy payments.

While most employers will not be affected by this guidance, employers who received subsidies from the program are obligated to complete a final reconciliation. CMS will reclaim payments if they are not supported by this report. The reconciliation process is complex and involves coordination among various partners, such as pharmacy benefit managers, insurers and the RDS program. The reconciliation process should be underway now so it can be completed by the deadline. The final reconciliation is due 15 months after the end of the plan year. The due date for a 2006 calendar year plan is March 31, 2008. Employers must access the **RDS website** to complete the reconciliation process.

3. NEW REQUIREMENT FOR MSP ENFORCEMENT

When an individual is enrolled in both Medicare and an employer's health plan, federal law determines which is primary (paying benefits without regard to other plans) and which is secondary (paying some or all of the expenses not covered by the primary plan). The secondary plan almost always pays much less than the primary plan. Over the years, the federal government has changed the law several times so that Medicare is the secondary payer in more and more situations, thereby shifting the cost burden to group health plans.

Mistakes happen and Medicare sometimes ends up paying first when it should have paid second. CMS has a reputation for taking draconian action in such cases, often hiring private debt collectors to pursue overpayments from employer plans even when the plans may not be at fault. In addition, a number of different penalties apply to MSP violations. Despite the aggressive (and expensive) tactics, CMS does not recover many claims that should be reimbursed. For additional information about Medicare secondary payer issues, please see ***Executive Signal*, Issue 5**.

A law enacted in late December is intended to reduce the cases of CMS overpayment. Insurers, TPAs and administrators of self-administered and self-insured plans will be required to provide to CMS information necessary to identify situations where the group health plan is or has been primary. (The form and manner of the report to CMS are as yet unspecified.) Since most companies do not self-administer their medical plans, the burden of compliance generally will fall on insurers and TPAs. For its part, CMS will share information about individuals enrolled in Medicare Part A or Part B with the insurer, TPA or the plan administrator.

This new requirement will likely present a substantial administrative burden, but it may prevent Medicare from paying first on claims for which it should pay second. Any plan sponsor that has received a demand letter from CMS can attest that helping CMS avoid overpayments is worthwhile.

The penalty for noncompliance with this new requirement is $1,000 per day for each individual for whom the information should have been submitted. This requirement becomes effective for health plans on January 1, 2009. A similar provision becomes effective July 1, 2009 for Workers' Compensation plans, liability insurers and no-fault insurers.