Group Health Plan (GHP) Reporting for Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

Frequently Asked Questions and Answers

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 mandates reporting of GHP arrangements. The current GHP reporting process includes the option to exchange primary prescription drug coverage information to coordinate benefits related to Medicare Part D. Under Section 4002 of the SUPPORT for Patients and Communities Act ("SUPPORT Act"), GHP Responsible Reporting Entities (RREs) will be required to report primary prescription drug coverage information beginning January 1, 2020. Below are answers to frequently asked questions on this reporting requirement.

Question 1: What prescription drug coverage data must be reported under the SUPPORT Act?

Answer 1: The SUPPORT Act requires reporting for Medicare beneficiaries who have prescription drug coverage other than or in addition to Medicare Part D, which is primary to Medicare. This includes prescription drug coverage for someone who may be Medicare eligible and currently is employed or is the spouse or family member of a worker who is covered by a prescription drug plan. The prescription drug coverage information required to be reported does not include individual prescription drugs prescribed to or used by a Medicare beneficiary. RREs are not to report coverage information on Medicare Part D Plans. Please note that Medicare Advantage Plans are not impacted by this change. More information on reporting requirements, data elements, and Medicare Secondary Payer (MSP) situations can be found in the Section 111 GHP User Guide.

Question 2: When are RREs required to begin reporting primary prescription drug coverage?

Answer 2: The SUPPORT Act requires RREs to begin reporting primary prescription drug coverage effective January 1, 2020. If an RRE is scheduled to report on January 26, 2020, it will need to include applicable primary prescription drug coverage information that is in effect/active for Medicare beneficiaries on or after January 1, 2020.

Please note that the effective date of primary prescription drug coverage should be reported, even if the effective date was prior to implementation of the Medicare Part D program. For example: John Doe has a primary prescription drug coverage effective date of 1/1/2001, but Medicare Part D did not go into effect until 2006. The coverage effective date of 1/1/2001 should be reported.

Question 3: In the case of reporting primary prescription drug coverage, which entity will be considered the RRE?

Answer 3: The entity considered to be the RRE for the purpose of reporting primary prescription drug coverage will depend on how the plan sponsor structures its contracts for medical, hospital, and prescription drug coverage. It should not be assumed that the RRE will be the entity that has direct responsibility of processing and paying the prescription drug claims.

For example, if the plan sponsor contracts with an insurer or TPA for hospital, medical and prescription drug coverage, then the insurer/TPA is considered the RRE and will be required to report primary prescription drug coverage. In this case, it does not matter whether the insurer/TPA administers the prescription drug coverage directly or contracts administration of prescription drug coverage to a third party such as a Pharmacy Benefit Manager (PBM).

However, if the plan sponsor contracts with an insurer or TPA for medical and or hospital coverage, but then independently contracts with another third party such as a PBM to administer prescription drug coverage, then that third party or PBM is considered the RRE.

Question 4: What method will RREs be required to use to report primary prescription drug coverage information?

Answer 4: The MSP Input File is the data set used to report GHP coverage information to Medicare. All GHP RREs must submit an MSP Input File to comply with Section 111 reporting requirements. The MSP Input File allows for the reporting of medical and hospital coverage along with the reporting of primary prescription drug coverage.

The necessary fields for prescription drug insurance coverage already exist on this file format and no changes will be needed to accommodate the reporting required for the SUPPORT Act. Full details on the MSP Input File can be located in the Section 111 GHP User Guide.

Question 5: What is the difference between the Basic and the Expanded reporting options under Section 111, and does an RRE need to use the Expanded reporting option in order to report primary prescription drug coverage as required under the SUPPORT Act?

Answer 5: The Basic reporting option is used to supply CMS with the required hospital and medical coverage information for Medicare beneficiaries and can be used to supply CMS with primary prescription drug coverage information. The Expanded reporting option includes all the Basic reporting information with the additional option of reporting supplemental prescription drug coverage information via the Non-MSP Input File. RREs do not need to use the Expanded reporting option in order to meet the requirements of the SUPPORT Act.

Question 6: Will RREs be required to engage in file testing for this change and, if so, when?

Answer 6: If a currently registered RRE is already reporting via the MSP Input File, then the RRE will not be required to test for the inclusion of primary prescription drug coverage information. However, RREs are welcome to test their changes related to these new requirements and can coordinate that testing with their Benefits Coordination & Recovery Center (BCRC) Electronic Data Interchange (EDI) Representative. Newly registered RREs will be required to test as part of the standard registration and set up process. Details about registration and testing may be found in the Section 111 GHP User Guide and RREs can contact the BCRC EDI Department for assistance at 1-646-458-6740.

Question 7: If an RRE is already voluntarily reporting primary prescription drug coverage information

will there be any change to that reporting under the SUPPORT Act?

Answer 7: If an RRE is currently voluntarily reporting primary prescription drug coverage and will continue to offer that coverage on behalf of the plan sponsor, then the RRE will continue to report it as the primary prescription drug coverage.

Question 8: Will the Query Response File contain Part D coverage information?

Answer 8: The Query Response File will not change. However, the MSP Response File will contain Part D enrollment information, meaning the effective date of coverage provided by current Medicare Part D Plan, for both the Expand reporting option and Basic reporting option if prescription drug coverage was submitted on the MSP Input File.

Question 9: As an RRE, are we required to retain any information returned on the MSP Response File?

Answer 9: RREs are required to process the response file and resend any incorrect information on the next quarterly submission but are not required to retain the information. RREs may, however, want to store the Medicare entitlement and enrollment information that is returned on the MSP Response File for their own internal coordination of benefits.

Question 10: What impact will the SUPPORT Act have on insurers that are submitting drug coverage information on the Section 111 Non-MSP Input File, or on insurers that are submitting the Drug Coverage Eligibility Records (E02) as part of the Medicare COBA data exchange for crossing claims from Medicare to supplemental insurance?

Answer 10: The Section 111 Non-MSP Input File and the Drug Coverage Eligibility Records (E02) are for the reporting of prescription drug insurance coverage that is supplemental to Medicare, when Medicare is the primary payer. The SUPPORT Act only requires reporting of prescription drug insurance coverage that is primary to Medicare and has no impact on these processes.

Question 11: As an RRE, we currently report hospital and medical coverage on the MSP Input File. We also cover primary prescription drugs and will need to report that coverage as well. How should we report the comprehensive coverage under the SUPPORT Act?

Answer 11: If the RRE is adding prescription drug coverage information to records that have already been submitted and accepted, the RRE should submit update records that include the prescription drug coverage information. RREs should use the appropriate coverage type (i.e. if the RRE currently reports Hospital and Medical coverage and are going to start including the drug coverage information, the RRE would use Coverage Type “W”). The RRE should not delete and re-add the already accepted records. RREs with any questions on the process should reach out to the EDI Representative.

Question 12: Is a Prescription Benefit that is a reimbursement plan, meaning that members are required to first pay for their medications out of pocket and, subsequently, request a reimbursement, reportable as “prescription drug coverage”?

Answer 12: Because this would be considered a Health Reimbursement Arrangement (HRA), the RRE should report records with a coverage type of “Z” (Prescription Drug HRA non-Network). If an RRE is already reporting HRA records using coverage type “R” (Health Reimbursement Arrangement), the RRE should continue to report as “R.” Please note, HRAs should only be reported for balances that are $5,000 or greater, per current CMS direction.