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Medicare & Medicaid State Children's Health Insurance Program Extension Act of 2007 (MMSEA)

Section 111: Mandatory Insurer Reporting (MIR)

Medicare Overview:

Medicare was established by Congress in 1965 to pay medical expenses for persons aged 65 or disabled. Initially, Medicare paid virtually all expenses for eligible participants. However, in 1980, in an effort to curb inappropriate Medicare spending, Congress passed the Medicare Secondary Payer Statue (MSP). The MSP was designed to prevent cost shifting to Medicare from other parties who might be responsible for, or have caused, the beneficiary's injury or illness. Under the MSP, responsible parties are called "primary payers" – the idea being that they should pay before Medicare – and include providers of Liability insurance, self-insurance, no-fault insurance and Workers' Compensation (WC has been primary since the original 1965 Medicare Act).

In July of 2001, the Centers for Medicare & Medicaid Services (CMS) introduced the Workers' Compensation Medicare Set-Aside (WCMSA) program, which recommended the review and approval of certain types of settlements by CMS. While this program has been successful for CMS over the last 8 years, it has only scratched to surface of Medicare's recovery potential under the MSP. In search of additional revenue to fund the rapidly depleting Medicare Trust Fund, Congress created Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). Medicare's recovery rights under the MSP remain unchanged, but they now have the means to enforce them in all instances under this new law.

With passage of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (also referred to as SCHIP or MIR), Congress updated the rules, and beginning in January 2011, CMS will require primary payers to provide data that will allow Medicare to recover payments that should have been paid by primary payers (commonly referred to as conditional payments or Medicare liens) and ensure that any additional future medical costs are covered by primary payers or the claimant's settlement proceeds, not Medicare. The regulations require primary payers to submit quarterly reports to CMS with detailed information about any claim involving a Medicare beneficiary.

Section 111 of the MMSEA will have serious implications beyond reporting, including:

- *Civil penalties of $1000 per day/claim for failure to comply with reporting requirements*
- *Requirements to discover/resolve conditional payments as part of any settlement agreement*
- *Increased usage of allocations to protect against future risks for the claimant and insurer*

Accordingly, companies that provide any form of Liability insurance, No-Fault Auto insurance,

and/or Workers' Compensation insurance to individuals who are Medicare beneficiaries must be in full compliance with Section 111 by January 1st, 2011 to prevent incurring liability pursuant to the MMSEA. MSP compliance has been required since December 5th, 1980.

Responsible Reporting Entities:

Entities responsible for complying with Section 111 are referred to as Responsible Reporting Entities (RREs). RREs must register with CMS via the Coordination of Benefits Secure Website (COBSW) between May 1, 2009 and September 30th, 2009. Registration after September 30th, 2009 is possible, but any exposure an RRE may have had prior to registration will not be mitigated. RREs must report quarterly, in a single electronic file, to CMS all claims involving Medicare beneficiaries where they have ongoing responsibilities for medicals (ORM) or cases resolved through a single payment settlement, judgment, or award as the total payment obligation to the claimant (TPOC). There are specific dates and thresholds around what types of claims need to be reported and RREs should review the CMS web-site to understand all of the guidelines and rules related to reporting exceptions on cases with ORM and TPOC. The site is *http://www.cms.hhs.gov/MandatoryInsRep.com*. Each RRE will receive a reporting period that is seven days in length. There are 12 cycles per quarter and 1 of 12 cycles will be assigned by CMS for each RRE ID. The reporting must be completed within the seven day period assigned by CMS after the completion of the registration process. The reporting timeframes are not uniform and a company with multiple-RRE IDs may have different reporting periods for various lines of business.

Insurance carriers are responsible for compliance with Section 111 for companies covered by an insurance policy with first dollar coverage. Companies who are truly self insured and hold a self insured retention (SIR) also must register and report claims that are within the SIR. If the claim exceeds the self paid deductible or SIR and moves into the insurer's layer, the insurer will become the RRE if they are funding the claim and the previous RRE will need to complete a final report indicating no further ORM. There is a great deal of conflicting information in the marketplace on this topic and CMS is expected to provide further guidance at some point.

Section 111 permits RREs to designate a third party to report claims and these entities are referred to as Reporting Agents. Third party administrators (TPAs) that manage claims and separate companies independent of the TPA can be appointed by the RRE as their Reporting Agent. Before designating a Reporting Agent, each RRE must register with CMS. The authorized representative for the RRE must have authority to enter into the CMS agreements on behalf of the RRE. An RRE has two options for SCHIP reporting:

- They can choose to be a direct reporting entity to CMS.
- They can choose to utilize a Reporting Agent to submit to CMS.

This can become a complex matter when an RRE's claims are managed by multiple administrators. CMS will only allow one input file per quarter per RRE ID. If you have multiple administrators you

must determine how those administrators will be reporting and decide if you wish to register multiple times and establish a separate RRE ID for each administrator or utilize a 3rd party data consolidator to roll-up all administrators data into a single report to CMS. There are substantial advantages to a single registration in these scenarios.

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Reportable Events:

Section 111 mandates the reporting of claims involving Medicare beneficiaries if there is Ongoing Responsibility for Medical (ORM), if there is a change from the initial report in key data elements, and when the case is resolved through settlement, judgment, or award (S/J/A) regardless of admission of liability. There are special exclusions for cases with ORM and thresholds for cases closed through S/J/A. To simplify matters, here are some general guidelines to note when discussing reportable events and the exclusions. One should review CMS guidance on this topic closely.

Reportable Events:

- Cases with ORM as of 1/1/10
- Cases with a TPOC closed through settlement, judgment, or award (S/J/A) on or after 10/1/2010
- Cases closed due to inactivity prior to 1/1/10, but are re-opened after 1/1/10 and have ORM as of 1/1/10

Excluded Events & Thresholds:

- Contested Cases Exclusion:
  - No ORM and no payments have been made to or for the benefit of the claimant (only excluded until S/J/A occurs).
- Total Payment Obligation to the Claimant (TPOC aka S/J/A amount) Thresholds Exclusions:
  - TPOC amounts below $5000 are not reportable between 1/1/10 and 12/31/11
  - TPOC amounts below $2000 are not reportable between 1/1/12 and 12/31/12
  - TPOC amounts below $600 are not reportable between 1/1/13 and 12/31/13
  - All TPOC amounts are reportable after 1/1/14
  - Limited to WC and Liability Claims
- WC Claims with ORM Exclusion:
  - For only Workers' Compensation Claims where all of the following are true; "medical only", loss time of no more than 7 calendar days, total payment does not exceed $750, and all payments have been made directly to the medical provider, are excluded from reporting until 1/1/11. Note: If ORM still exist as of 1/1/11, these cases will be reportable in the next quarterly cycle.

CMS requires submission of hundreds of data elements for each claim that meets the reporting criteria. Section 111 reporting requirements were originally scheduled to go into effect July 1, 2009. The period between January 1st, 2010 and December 31st, 2010 will now be a test phase for the transmission of data from RREs to the CMS. RREs must begin submitting actual data in the first quarter of 2011. Failure to comply with the reporting requirements of Section 111 could result in civil money penalties of $1,000 per day per claim for noncompliance. It is wise to start this process sooner than later as registration, data testing, live return response, claims data back-fill, and MIR data testing are all steps that need to be complete prior to MIR live data feeds.

Impact on Settlements:

Implementation of the new rules is expected to complicate the settlement of all claims. Although

SCHIP merely establishes claim reporting requirements, the MSP is also at work here and happens to be administered by CMS – the same entity responsible for enforcing Section 111 Reporting. CMS has the ability to enforce their Secondary Payer rights on every claim now that they have knowledge of them. The industry should expect:

- Numerous conditional payment recovery letters from CMS on old claims.
- CMS stopping payments for medical benefits tied to injury related diagnosis.
- Post-Settlement, CMS exercising it's authority to collect the entire settlement amount.

There is an absolute need to develop claims handling practices now to mitigate the exposure to these rights of recovery. It is imperative that claims handlers be knowledgeable about what to do when a conditional payment recovery letter arrives from CMS, legal counsel must be prepared to address conditional payment and consideration of Medicare future interests in settlements, and proper disclosure needs to be made with regard to Medicare rights of recovery when a settlement is consummated. Contrary to urban legend, there is no requirement to seek CMS review and approval of a liability settlement. While CMS will review and approve certain types of Workers' Compensation settlements, the burden is on the liability insurer to demonstrate that it adequately protected Medicare's interests in each settlement. Insurers should measure their tolerance for risk carefully.

Stay Alert:

CMS continues to publish news, alerts, memorandum, conduct telephonic "Town Hall" meetings, and update User Manuals. There is a very high probability that something has changed from the time this article was written to the moment when you read it. Stay alert and pay attention to the changes. Gould & Lamb will continue to monitor this matter and provide updates as necessary.

Should you have any questions, please do not hesitate to contact 866-672-3453 or online at www.gouldandlamb.com. Thank you for your interest in this topic.