

Medicare Mandatory Insurer Reporting

New Requirements under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007

(Updated effective July, 2009)

What Is Medicare?

Medicare is a Federal program that pays for certain covered health care provided to enrolled individuals age 65 and older, certain disabled individuals, and individuals with permanent kidney failure. CMS – the Centers for Medicare & Medicaid Services – is the agency of the Federal government responsible for the oversight of the Medicare program, including implementation of the new Mandatory Insurer Reporting (MIR) requirements discussed below.

What is Medicare’s relationship to casualty insurance and self-insurance programs?

Medicare has been a “secondary payer” to workers compensation since the passage of the Medicare law in 1965, and has been a secondary payer to liability, no-fault and other forms of insurance, including self-insurance, since the passage of the Medicare Secondary Payer (MSP) statute in 1980.

In late December 2007, Congress passed a new amendment to the MSP known as Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). This law requires all primary payers “to report to the Secretary of the Department of Health and Human Services all information the Secretary specifies is necessary to ensure proper coordination of benefits with the Medicare program.” Effective July 1, 2009, all liability insurers, no-fault insurers, workers compensation insurers and self-insurers will be required to identify and report to the Secretary all Medicare beneficiaries who have received a settlement, judgment, award, or other payment.

For reporting purposes, a “Medicare beneficiary” includes anyone who is a current beneficiary or was a beneficiary at any time prior to the event that triggers the reporting requirement.

What are the new requirements under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007?

The 2007 amendments to the MSP provisions require certain enterprises, referred to as “Responsible Reporting Entities” or “RREs” to report specified information regarding “non-Group Health Provider (non-GHP)” arrangements (liability insurance, no-fault insurance, and workers compensation, including self-insurance) to CMS, April 1, 2010, retroactive to January 1, 2010. Data will be submitted electronically to CMS’ Coordination of Benefits Contractor (COBC). An RRE may report directly, or may assign an agent (usually a third party administrator (TPA)) to report on behalf of the RRE.

CMS has issued a final User Guide, which is subject to revision. A current copy of this document, as well as any addenda, will be available on Travelers.com.

Do these requirements supersede prior Medicare requirements?

The new Mandatory Reporting requirements do not change or eliminate any existing MSP Act requirements. Medicare is still entitled to recover for any conditional payments that were otherwise payable under a “primary plan,” and Medicare is still entitled to require Medicare Set-Aside Allocations (MSA) for workers compensation settlements meeting certain requirements. Travelers has had a comprehensive workflow in place since Medicare began to require the use of MSAs in workers compensation claims, including the establishment of our In-House Consultant program to perform MSAs and administer the MSA process.

Key implementation dates as of May 11, 2009 alert:

- **05/01/09 - 09/30/09** Electronic registration via the Coordinator of Benefits Contractor Secure Website for all liability/no-fault/workers compensation RREs.

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- **07/01/09** Testing period begins for Query input files (test and production) for all liability/no-fault/workers compensation RREs.
- **01/01/10 - 03/31/10** All liability/no-fault/workers compensation RREs **must** submit their first Section 111 Claim Input files for testing (may submit for production) based upon a predetermined schedule with the COBC.
- **04/01/10** All liability/no-fault/workers compensation RREs must be in compliance with submission of Section 111 Claim Input production files by this date. While CMS extended the testing period, it did not extend the reporting period.

Who is an RRE?

For all non-GHP plans, Congress has defined the term “applicable plan” to include all forms of liability insurance (including self-insurance), no fault insurance (including Personal Injury Protection (PIP) and medical payment (MP) provisions), and workers compensation laws or plans, whether insured or self-insured. This is an important term because the “Applicable Plan” is the Responsible Reporting Entity. Under the Medicare law an entity is “self insured” if it carries its own risk, whether by a failure to obtain insurance, or otherwise, and includes payments within a deductible when those payments are made to a beneficiary directly or through a third party (see 42 U.S.C 1395(b)(2)(A)).

Generally speaking, an entity is an RRE if that entity is primarily responsible for payments to a Medicare beneficiary. **The insurer will be the RRE under the vast majority of insurance programs, and, more specifically, under the following situations:**

- The insurer makes qualifying payments to a Medicare beneficiary under a guaranteed cost policy.
- The insurer makes qualifying payments to a Medicare beneficiary under a deductible or retrospectively rated policy for which the insurer then seeks reimbursement from the insured for amounts paid within the deductible.
- The insurer makes qualifying payments to a Medicare beneficiary under an excess or umbrella program, rather than reimbursing the insured or underlying insurer for payments they made in excess of their assumed layer of responsibility.

If you are a self-insured entity as defined by Medicare and you make payments directly (or through a third party administrator) to the beneficiary, then you are the RRE under the following situations:

- You have a true self-insured retention and make payments directly (or through a TPA) to a beneficiary.
- You have a deductible or self-funded insurance program, and make payments directly (or through a TPA) to a beneficiary. [Please note that if the insurer makes payments directly to a beneficiary for amounts in excess of the deductible, they are the RRE for payments they make; however, if you make payments in excess of the deductible or self-funded retention and seek reimbursement from the insurer, then you are the RRE for the entire payment you make to the beneficiary.]
- You have a self-insured plan with excess coverage – you will be the RRE for any payments made directly (or through a TPA) to a beneficiary up to your self insured retention, and the excess carrier will be the RRE for any payments it makes directly (or through a TPA) to a beneficiary above the retention.

What are the penalties for non-compliance?

The statutory penalty that may be assessed against an RRE for non-compliance is \$1,000 per claim per day of non-compliance. CMS has verbally stated that its initial intent is not to fine companies that are making a good-faith effort to comply with the law – its main objective is to obtain a “clean

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data feed.” CMS has indicated that it expects RREs to clean up bad data, and that it does intend to levy penalties for repeated submissions of “junk” data.

What roles will Travelers and its entities or Constitution State Services play under its various insurance programs with respect to mandatory reporting requirements?

Travelers and all its entities will register as the RRE for those insurance programs where Travelers is the insurer and makes payment directly or through a TPA to a Medicare beneficiary. Travelers' entities include Discover Re, Travelers of Massachusetts, Northland, Gulf, Associates, and Bond & Financial.

Where Travelers subsidiary Constitution State Services (CSS) is the TPA, it will be necessary for the self-insured entity to register as the RRE. For insured entities where claims are administered through CSS but who have an insurance policy through another insurer, it will be necessary for the insured and its insurer to determine who the RRE should be under that insurance program. We will be pleased to assist the account, the broker and any other party in this evaluation. CSS is fully prepared to be the reporting Agent on behalf of the self-insured entity or on behalf of an insured with another carrier, if so designated by the self-insured or the carrier, as applicable.

What must I do to comply with the law?

If you are an insured under a guaranteed cost policy or a straight deductible program where the insurer is making the payments to the Medicare beneficiary, you do not have to do anything to comply. As will be detailed below, you can be assured that Travelers will take all steps to register as an RRE and will be responsible for all mandatory reporting. Please be advised that if you fail to report a claim and/or self-pay the claim you are the RRE and subject to Medicare fines.

If you are self-insured you will have to register as an RRE. CMS will consider you to be self-insured in those instances where you are truly without insurance, you have an SIR, SFR or large deductible that you pay or fund directly, or if you have some other type of similar “fronted policy” arrangement, and whether or not you have excess coverage above your retention.

If you are unsure of your status under your insurance program with Travelers, please contact your broker and Travelers, and we will be glad to assist you in evaluating your particular situation.

If I am required to do so, how do I register as a Responsible Reporting Entity (RRE)?

CMS has now finalized the registration process. While you should consult the latest User Guide for complete information on this process, here are the basic steps you will follow in the registration process:

- An authorized RRE representative completes and submits basic registration information through the COBC's secure website between 5/1/09 and 9/30/09.
- The COBC will send a letter via USPS with a PIN to complete the registration.
- The RRE must designate an “Account Manager” who will control the overall account profile.
- The authorized RRE representative provides the PIN to the designated Account Manager, who then uses the PIN to access the website and complete the registration Account Set Up.
- The COBC processes the registration and sends an email with a “Profile Report” to the RRE representative, with the assigned Reporter ID and file submission timeframes. The authorized representative will “approve” the information submitted by the account manager by signing and returning the last page of the profile report. The RRE ID provided during registration must be used on all data files submitted in connection with this RRE.
- The RRE may designate an “agent” for reporting purposes during registration. For CSS customers, we will contact you separately with instructions for designating CSS as your reporting agent.

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- The Account Manager can also register "Account Designees" – usually an employee of the RRE, TPA or Agent who needs to monitor the status of files. For CSS customers, we will contact you separately to provide you with the names of account designees. You can also name your own employees as account designees, as well.
- The COBC secure website is used by the RRE (via Account Manager or Account Designee) to manage the RRE profile, review file transmission history and update account information.

If I am an RRE, should I designate an "Agent" for reporting purposes?

If you are an RRE and your claims are administered by a TPA, you may contract with that TPA as your agent for reporting purposes. Anyone who can put the data into a form acceptable to CMS can be an "agent" – CMS does not and will not endorse any entity. You can designate different agents for different lines of business if you choose.

Please keep in mind that while you can contract with a third party to handle your data reporting requirements, CMS has stated that the RREs remain solely responsible and accountable for complying with CMS' requirements, notwithstanding any agreement between the RRE and the agent.

What claims will CMS require to be reported?

Effective April 1, 2010 all liability insurers, no-fault insurers, workers compensation insurers and self-insurers will be required to identify and report to the Secretary all Medicare beneficiaries who have received a settlement, judgment, award, or other payment, or where we have assumed ongoing responsibility for medical payments, since January 1, 2010. By April 1 – June 30, 2010 live submission window, we will be required to report any claims where we assumed an ongoing responsibility for medical payments prior to July 1, 2009.

For workers compensation, no-fault, PIP, and any other coverage whereby the insurer or self-insurer makes any medical payment to or on behalf of a Medicare beneficiary, the RRE must report when responsibility is assumed for medical payments. This will usually be the date of the initial payment, or, if the claimant becomes a Medicare beneficiary at some point after an ongoing medical payment obligation has been assumed by the RRE, the RRE must report as soon as it discovers the claimant is a Medicare beneficiary. If the insurer or self-insurer assumes an ongoing medical payment obligation, the entity must monitor the claim and report a termination of that ongoing medical payment obligation (usually through exhaustion of limits, death of the beneficiary, or final settlement of the medical payment obligation). This applies to claims that were open as of January 1, 2009. Workers compensation "ongoing responsibility for medical" (ORM) for "medical only" claims is also subject to a \$600 threshold, which also requires that lost time cannot exceed 7 days, and payments for medical were made to the health care provider only. CMS is considering raising the dollar threshold and is seeking additional data on this issue.

For liability and other similar coverages, the reporting obligation accrues when a settlement is made or a judgment is incurred. You may also incur a reporting obligation if any other payment is made to or on behalf of that beneficiary (such as an advance against settlement or the payment of any medical bills). Typically, liability claims (and some workers compensation claims) are paid at one time, which CMS terms the "total payment obligation to claimant" (TPOC). The reporting threshold for TPOC claims is \$5,000 per claim report for calendar year 2010, and will be reduced to \$600 per claim by 2012.

For all claims, the RRE must correct and resubmit any records found to have been in error in previous submissions. Subsequent quarterly file submissions are to contain only new or changed claim information using add, delete and update transactions as prescribed by CMS.

What process has Medicare established for mandatory reporting?

When mandatory reporting has been triggered by settlement, judgment, award, or other payment, or any time prior thereto, the RRE (or its agent) will send an electronic query to Medicare to see whether the claimant is a Medicare beneficiary. This query must include the claimant's social security

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number, date of birth, gender and name. The COBC will then provide a "disposition code" that will indicate either the claimant is a current or former Medicare beneficiary, or that the COBC was not able to match the supplied data to a current or former Medicare beneficiary. If the query results in a match on both the SSN and at least 3 out of the 4 remaining data, the COBC will supply the missing piece of data. The COBC will also supply the Health Insurance Claim Number (HICN), which will be used on subsequent reporting. The COBC will not provide any additional information, such as the date the beneficiary became entitled to Medicare, or whether the beneficiary elected additional coverages. Queries should not be sent with missing data.

If there is no data match, then no report is required. Please note that it is possible that either the SSN and/or two other pieces of data are incorrect, so effort should be made to review and correct such data prior to the next query. Queries may be submitted as frequently as monthly, and should be resubmitted monthly for all claims on which there is no current data match but the RRE has assumed an ongoing responsibility for medical payments (ORM), until the ORM is terminated. If a data match occurs during a later query, then a report will have to be made in the following reporting period.

Each RRE will be given a specific 7-day window every quarter in which to report all claims that trigger the reporting requirement. If the query results in a data match, the RRE must report the required data in the next quarterly reporting period; if the payment date that triggers reporting responsibility occurs within 45 days of the next quarterly submission period, the RRE may submit that report in the following quarterly reporting period. The RRE will send a file to the COBC that may contain up to 135 data elements for each data record. If CMS rejects a data record, the RRE will then be given an opportunity to clean up the data and resubmit the record in the next quarterly file submission. CMS has indicated that repeated submissions of "junk" data may result in penalties for non-compliance.

Please note that in CMS' current proposal it is requiring reporting of many data elements that were not typically captured in the handling of claims, or were not captured in a format easily accessible or capable of submission to CMS. It is critical to obtain this new data on all cases going forward so that reporting may take place as required by CMS.

What steps has Travelers instituted to prepare for mandatory reporting?

Immediately upon passage of the Act, Travelers brought together a multidisciplinary group from every functional area, line of business and business unit in the company, to evaluate the legal requirements, assess our technology and infrastructure, and prepare for full compliance. In addition to working through the American Insurance Association (AIA), Travelers has also established contact with CMS and submitted inquiries directly to CMS.

For all products for which Travelers will be the RRE, Travelers will be prepared to fully comply with every time frame set forth by CMS for Section 111 reporting. For our alternative risk transfer products in which our "self insured" customers directly pay or fund their losses, those customers will be deemed the RRE, and we will be prepared to assist in the process of designating an agent to perform the reporting function.

To date, Travelers has completed the following actions applicable to all lines of business:

- Established a workflow and protocol immediately to collect all necessary data elements.
- Updated systems to capture all requisite data in an accessible format that will be acceptable to CMS.
- Prepared systems to submit queries and data records to the COBC.
- Assigned an Account Manager and identified particular Agents for TPA-handled claims.
- For TPA Managed business where Travelers is the RRE and has not elected to report directly, we will either enter into agreements with TPAs to act as our reporting agents, or to send the data to another designated reporting agent of our choice.

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There are a number of areas in which CMS has yet to issue guidance, including special situations related to trusts, mergers, and bankruptcies. CMS has yet to offer final guidance on "mass tort" claims, and product liability designations. . We will continue to work with CMS on these and all other issues related to the mandatory reporting requirements.

Travelers has taken the proper steps to fully comply with the new Section 111 of the MMSEA. Please do not hesitate to contact your agent or your Travelers representative with any questions on what we are doing to meet the requirements of this new law. Travelers will continue to closely monitor these and all other issues raised by these new requirements, and will continue to actively participate in all opportunities provided by CMS to contribute to the development of these requirements. We will update this memorandum as Medicare continues to revise and refine the process.

Key Acronyms related to this Act:

- CMS: Centers for Medicare and Medicaid Services
- COBC: Coordination of Benefits Contractor
- E-CODE: External Cause of Injury Code
- HICN: Health Insurance Claim Number
- ICD-9 CM Diagnosis Code: Diagnosis code (describes the alleged injury/illness)
- MIR: Mandatory Insurer Reporting
- MMSEA: Medicare, Medicaid and SCHIP Extension Act of 2007
- MSA: Medicare Set-Aside Allocation
- MSP: Medicare Secondary Payer Act
- ORM: Ongoing Responsibility for Medical
- PIP: Personal Injury Protection
- MP: Medical Payment Coverage
- RRE: Responsible Reporting Entity
- RRE ID: Responsible Reporting Entity Identification Number
- SFR: Self-Funded Retention
- SIR: Self-Insured Retention
- TPOC: Total Payment Obligation to Claimant
- TPA: Third Party Administrator

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