

**Medicare, Medicaid and State Children's  
Health Insurance Program (SCHIP)  
Extension Act of 2007 (MMSEA Section 111)**



The reporting rules for liability insurance (including self insurance), no-fault insurance and workers compensation insurance were changed December 29, 2007 obligating primary payers (Responsible Reporting Entities or RREs determined by who funds/pays the losses) to identify claimants entitled to Medicare and report them electronically.

The rules are complex and the penalty for failure to properly notify Medicare is \$1000 per day, per claimant. In many cases your insurer will be the RRE. But when there are deductible or retention plans you could become the RRE. Claim reporting requirements begin July 1, 2009 for registered RREs. Following is some general information to help you understand this complicated process. Also, Hays has partnered with compliance specialists Gould & Lamb who have provided more detailed information. In addition they have provided the attached materials. For more information you can contact Gould & Lamb directly or call your Hays representative to learn more about two webinars Gould & Lamb will host in the very near future.

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### **SCHIP Historical Overview**

In December 2007, The State Children's Health Insurance Program Extension Act (SCHIP) was passed by Congress. Section 111 of the bill is designed to provide a funding vehicle for the program by establishing reporting requirements. A civil **financial penalty of \$1,000 per day, per claimant**, is assessed for non-compliance with the requirements. This legislation impacts the handling of group health plans and workers' compensation, liability, auto no-fault and self-insurers claims, defined by Centers for Medicare and Medicaid Services (CMS) as non-Group Health Plans (NGHP), and are designated the primary payer. The legislative intent is for Medicare to continue to be the secondary payer if a primary payer exists.

Section 111 allows CMS to identify those claims where Medicare has a right of recovery against the primary payer. Any entity that pays a settlement, judgment, award or other payment to Medicare eligible beneficiaries on or after July 1, 2009 is required to report the claim to CMS. The law requires that 100 percent of claims owned by a NGHP entity be examined to determine if the claimant is currently Medicare eligible.

### **Responsible Reporting Entity (RRE)**

**CMS considers the funding source responsible for payment to the Medicare beneficiary to be the RRE.** While MMSEA Section 111 also applies to Group Health Plans, the focus of this discussion pertains to Subsection 8 of the law for non-Group Health Plans; workers' compensation, liability and no-fault insurance. This requirement applies to all insurers, including self-insurers, for non-Group Health Plan claims. It is important to note that CMS never considers third party administrators (TPA's) to be the RRE, for the purposes of Subsection 8.

#### **RRE examples:**

- Insurers are the RRE for workers' compensation, liability or no-fault insurance.
- Self-insurers are the RRE for self-insured workers' compensation, liability or no-fault insurance.
- Insurers are the RRE for carrier funded and paid deductible programs, reimbursed by the employer.
- Workers' compensation insurers are the RRE for programs indirectly funded by the employer.
- The employer is the RRE when the workers' compensation program is directly funded by the employer.
- The insurer is the RRE for workers' compensation deductible programs when the employer purchases workers' compensation insurance from the carrier.
- The self-insurer is the RRE for self-insurer funded payments below and above the excess limit and seeking reimbursement from the re-insurer/excess carrier.
- The self-insured pool or captive is the RRE if the pool or captive is the funding source and has full control of payment and resolution of the claim, and meets the 3 criteria defined in Subsection 8.
- The self-insured pool or captive member is the RRE when the member is the funding source and controls payment and resolution of the claim.

- Texas non-subscriber plans are considered to be workers' compensation plans by the federal government and are required to comply with all reporting requirements.

It is important to note that in excess cases where the party who controls the release of the money changes when the excess level is reached. The claim is reportable by both the self-insurer and the excess carrier with the self-insurer noting the change in ongoing responsibility for medicals when the excess level was met.

Please contact Gould & Lamb with specific scenarios and questions.

### **Responsible Reporting Entity (RRE) Registration**

**All RRE's are responsible for registering as soon as possible** with CMS on the Coordination of Benefits Secure Website (COBSW), and comply with requirements of Section 111 of the MMSEA, from May 1, 2009 through June 30, 2009 using the web portal at [www.Section111.cms.hhs.gov](http://www.Section111.cms.hhs.gov).

- Detailed registration instructions are available from the CMS NGHP User Manual, which is available at: <https://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf>.
- CMS allows RRE's to use Reporting Agents to perform the reporting functions, but require that the RRE is solely responsible and accountable for complying with all CMS instructions for implementing Section 111.
- CMS will provide RRE's with online training. CMS's Coordinator of Benefits Contractor's (COBC) education coordinator, at (646) 458-6740, can notify you by e-mail once the training becomes available.

### **Registration and Account Setup Process**

Section 111 registration and account setup is a five-step process, as outlined below. More detailed information regarding this process is contained in the NGHP User Manual.

Step 1: Identify an authorized representative, account manager and other COBSW users. (Gould & Lamb is available to serve this function.)

Step 2: Determine reporting structure

Step 3: RRE registration on the COBSW

Step 4: RRE account setup on the COBSW – Account Manager

Step 5: Return signed RRE profile report – authorized representative

- Beginning May 1, 2009, the RRE must go to [www.Section111.cms.hhs.gov](http://www.Section111.cms.hhs.gov) to register.
- Watch for the assigned PIN and credential that will be mailed from CMS.
- Immediately scan and e-mail credentials to your assigned Account Manager, along with an estimated number of open claims per RRE ID.
- Watch for your profile report that will be mailed from CMS.

- Return the signed Profile Report to CMS. E-mail a copy to your Account Manager.

### **Electronic Data Reporting**

CMS requires all reporting to be done electronically and in compliance with established protocols outlined in the NGHP User Manual, along with the data elements that must be reported.

### **Reporting Agents**

RRE's should have discussions with their TPA(s) and carrier(s) to determine if they have the capability to act as the RRE's Reporting Agent. Confirm they are in compliance with Section 111.

### **CMS Data Testing Period**

All RRE's are required to comply with CMS data requirements to ensure proper data feed of the 180+ data elements required by CMS. The data feed testing period is July 1, 2009 to December 31, 2009.

### **CMS Live Data Reporting**

RRE's can begin live data transmissions to CMS beginning October 1, 2009 to December 31, 2009. CMS exempts those RRE's whose data feed testing was not successful and allows an extension to begin live data transmissions on January 1, 2010. Any claim settled prior to July 1, 2009 is not reportable to CMS. Any claim settled on or after July 1, 2009 is reportable to CMS.

### **Quarterly Reporting**

CMS requires quarterly reporting by RRE's for new claims involving Medicare beneficiaries that received settlements, judgments, awards or medical payments during the quarterly reporting period. Any changes or corrections to claims previously reported must be provided by the RRE, along with final notification on any previously reported claims if the Ongoing Responsibility for Medical Payments (ORM) has ended.

- An active workers' compensation or liability claim with ongoing medical treatment as of January 1, 2009 is reportable.
- If a claim is closed with no active medical treatment of any kind as of January 1, 2009 it is not reportable. However, if this type of claim is reopened for medical treatment or payments of medical treatment after January 1, 2009, then it has to be reported.
- Please note that after two years, people receiving Social Security Disability Insurance (SSDI) benefits are automatically enrolled in Medicare, so their claims would be reportable.

### **Reporting Thresholds**

CMS requires the total settlement value of the NGHP claims be reported, including indemnity and medical benefits and attorney fees. Following are the reporting thresholds and time frames to CMS for settlements, judgments or awards or other payments to Medicare eligible beneficiaries:

- July 1, 2009 to December 31, 2010: Settlements of \$5,000 and greater must be reported
- January 1, 2011 to December 31, 2011: Settlements of \$2,000 and greater must be reported
- January 1, 2012 to December 21, 2012: Settlements of \$600 and greater must be reported

- January 1, 2013 and later: **All** settlements must be reported, including those involving gift cards, coupons, gift certifications, vouchers, etc.

For workers' compensation claims, all of the following conditions must apply in order for a claim to be considered not reportable to CMS:

- Must be a Medical Only claim
- Time loss from work cannot exceed 7 calendar days
- All medical payments must have been made directly to the medical provider
- Total payments do not exceed \$600.

**MMSEA Section 111 Critical Dates:**

- May 1, 2009 to June 30, 2009: Required Responsible Reporting Entity (RRE) registration on Coordination of Benefits Secure Website (COBSW)
- July 1, 2009 to December 31, 2009: Data feed testing to CMS
- July 1, 2009 to December 31, 2009: Settlements of \$5,000 and greater must be reported to CMS
- October 1, 2009 to December 31, 2009: Mandatory claim reporting to CMS

**MMSEA Acronym Definitions:**

- COBC: Coordinator of Benefits Contractor
- COBSW: Coordination of Benefits Secure Website, for RRE registration
- CMS: Centers for Medicare and Medicaid Services
- CSA: Claim Settlement Allocation
- MIR: Mandatory Insurer Reporting
- MMSEA: Medicare & Medicaid State Children's Health Insurance Program Extension Act
- MSA: Medicare Set Aside allocation
- MSP: Medicare Secondary Payer
- NGHP: Non-Group Health Plans (workers' compensation, liability, auto no-fault)
- ORM: Ongoing Responsibility for Medicals
- RRE: Responsible Reporting Entity
- RRE ID: Responsible Reporting Entity Identification
- SCHIP: State Children's Health Insurance Program
- TPA: Third Party Administrator
- TPOC: Total Payment Obligation to Claimant

**Links to Medicare manuals, memos, bulletins and SCHIP MIR information:**

**NGHP User Guide (3/20/09):**

<https://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf>

**Definitions and Reporting Responsibilities – Attachment A:**

<https://www.medallocators.com/Documents/CMS%20Definitions%20of%20an%20RRE.pdf>

**Alert for Liability, No-Fault, Workers' Compensation Insurance (3/20/09):**

[https://www.cms.hhs.gov/MandatoryInsRep/Downloads/Alert\\_UserGuideSupp\\_NGHP.pdf](https://www.cms.hhs.gov/MandatoryInsRep/Downloads/Alert_UserGuideSupp_NGHP.pdf)

**Gould & Lamb website:**

[www.gouldandlamb.com](http://www.gouldandlamb.com)

**Disclaimer:**

The information contained in this memorandum is a general overview of the Medicare SCHIP Act and is not intended to provide specific direction or recommendations about how to comply with any or all SCHIP regulations and requirements, or legal advice regarding any specific facts or circumstances. Clients are urged to consult with their legal counsel or Gould & Lamb for expert direction, advice and recommendations.