



THE MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM EXTENSION ACT OF 2007 (MMSEA)

In the early 1980s, Medicare became aware of many cases where Medicare made payments for medical treatment that should have been the responsibility of other third party payers, such as employer-sponsored health plans, workers' compensation, liability and no-fault insurance. Many laws have been enacted shifting the responsibility for payment of expenses for Medicare-covered individuals to third party payers.

The first laws passed to help reverse this process were enacted in 1982 and 1983 under omnibus tax laws, dealing with what has been termed "the working aged" – those individuals who continue full-time employment after attaining Medicare age. Under this legislation, employer-sponsored health plans were required to continue to provide coverage for these individuals, and their dependents, and this coverage was primary to Medicare.

While this solved some of the problem, there still remained many cases where Medicare paid claims for which other third party payers were responsible. Consequently, in the early 1990s, Medicare began enforcing the Medicare Secondary Payer (MSP) provisions of the laws. Medicare started questioning employers and insurers regarding the status of active and former employees. When Medicare determined they had paid in error, demands were made on employers and insurers to reimburse Medicare. It was not uncommon for Medicare to go back seven or eight years in this collection process.

Most of Medicare's focus from 1980 through the mid-2000s was on employer-sponsored medical plans that provided coverage for individuals who were actively employed beyond their Medicare entitlement ages. Gradually, the Centers for Medicare and Medicaid Services (CMS) realized that the issue of third party claim liability was larger than merely employer-sponsored medical plans and Medicare. Medicaid, which provides coverage for low-income families, may also pay expenses for which an employer-sponsored medical plan could be responsible. In addition, workers' compensation and liability insurance may also be responsible for some expenses Medicare, Medicaid, and other federal or state programs are paying.

In December 2007, Congress passed The Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 (MMSEA). This Law incorporated a far-reaching reporting process that includes group health plans, workers' compensation, liability and no-fault insurance.

The regulations established under MMSEA address the various types of insurance plans differently. While there are differences, two items are constant:

- ◆ Responsible Reporting Entity (RRE) – The party considered the funding source and responsible for paying the Medicare beneficiary and for electronic reporting to CMS. The RRE is different for Group Health Plan (GHP) and Non-Group Health Plan (NGHP) programs.
- ◆ Data Sets to be Reported – Data requested by CMS does not vary extensively between GHP and NGHP programs.

GHP and NGHP programs will be discussed separately since CMS's regulations are different.

GROUP HEALTH PLANS

Because of the prior experience CMS has had with the Medicare Secondary Payer program, CMS is aware that these programs are usually either fully-insured with a carrier paying the claims or self-funded with a contract administrator processing the claims under the plan. There are a few self-funded plans that process and pay their own claims. Under the GHP provisions, the RRE is further defined as carriers, third party administrators, or the self-funded/self-administered plan.

For the fully-insured plans and the self-funded plans using outside administrators access to the information necessary to provide CMS with complete data information is hindered by the Health Insurance and Portability Act of 1996 (HIPPA) and ensuing Privacy and Security requirements. HIPPA restricts plan sponsors from ready access to detailed information about specific claim activity. Therefore, the requirement to provide the detailed data necessary was placed on the fully-insured carriers and the third party administrators (TPAs) for self-funded but not self-administered health plans. Self-funded and self-administered health plans are responsible for their own reporting.

One of the data elements required by CMS are the Social Security Numbers (SSNs) for each claimant, whether the employee or a dependent. Since this information was not routinely required by carriers and TPAs prior to this reporting process, these entities (Continued on page 2)



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must work with the employer of the health plan to obtain the necessary SSNs. These entities began requesting information at the end of 2008 and into 2009. Since the reporting process is ongoing, obtaining the SSNs is being done retro-actively for existing employees and their covered dependents and concurrently as new employees and covered dependents are added to the health plans. Employers who refuse to provide this information can be subject to a penalty of \$1,000/day for each individual for whom information is not provided.

Occasionally employees will refuse to release the SSNs of their dependents. In this case, the employer can request that the employees sign a form indicating their refusal. If there is ever an issue on these employees' dependents, the refusal form will help transfer any liability to the employee. Most employers will have the SSNs for their employees for tax purposes.

Reporting by the RREs began slowly over 2009 and should be fully operational in 2010. The first reporting was limited to those individuals fitting into carefully defined categories:

- ◆ All Active Covered Individuals (ACIs) between the ages of 45 and 65 who have coverage under the plans based on their own or a family member's current employment status.
- ◆ All ACIs age 65 or older who have coverage based on their own or a family member's current employment status.
- ◆ All ACIs who have been receiving kidney dialysis or have had a kidney transplant regardless of their own or a family member's current employment status. Or
- ◆ All ACIs under age 45 who are known to be entitled to Medicare and have coverage on their own or a family member's current employment status.

While this first initial reporting only dealt with a few limited classes, since the Law extends into Medicaid and the State Children's Health Insurance Programs (SCHIP), it is believed that the reporting process will be expanded to include all covered dependents. Most carriers and self-insured plans have begun collecting the SSNs for all dependents to expedite this future reporting requirement.

Once CMS has identified an individual where it believes that a third party should be responsible for primary payment, it will issue a request letter to the employer identified in the reporting process. This letter is similar to request letters used in the MSP process. However, instead of responding in a paper format, employers are now asked to respond via a website. The CMS letter provides codes that the employer must use to access the questionnaires. The first step is to provide information about the plan's coverage for a requested period of time. Once this information is entered, the employer must leave the website. CMS then cross matches the information against their file. In a couple days, the employer can go back to the website and

access a listing of those individuals for whom more detailed information is required. For these individuals, the employer is asked to verify the employment and coverage status which may relate to any claim in question. Failure to respond within 60 days of the receipt of the original letter may result in a penalty of up to \$1,000 for each worker for whom an inquiry was made.

If CMS determines they have paid in error, they will request a repayment from the carrier and the employer/plan sponsor. CMS has the authority to do this under various federal laws and can assess penalties if they believe the carrier/employer is intentionally trying to evade payment.

NON-GROUP HEALTH PLANS

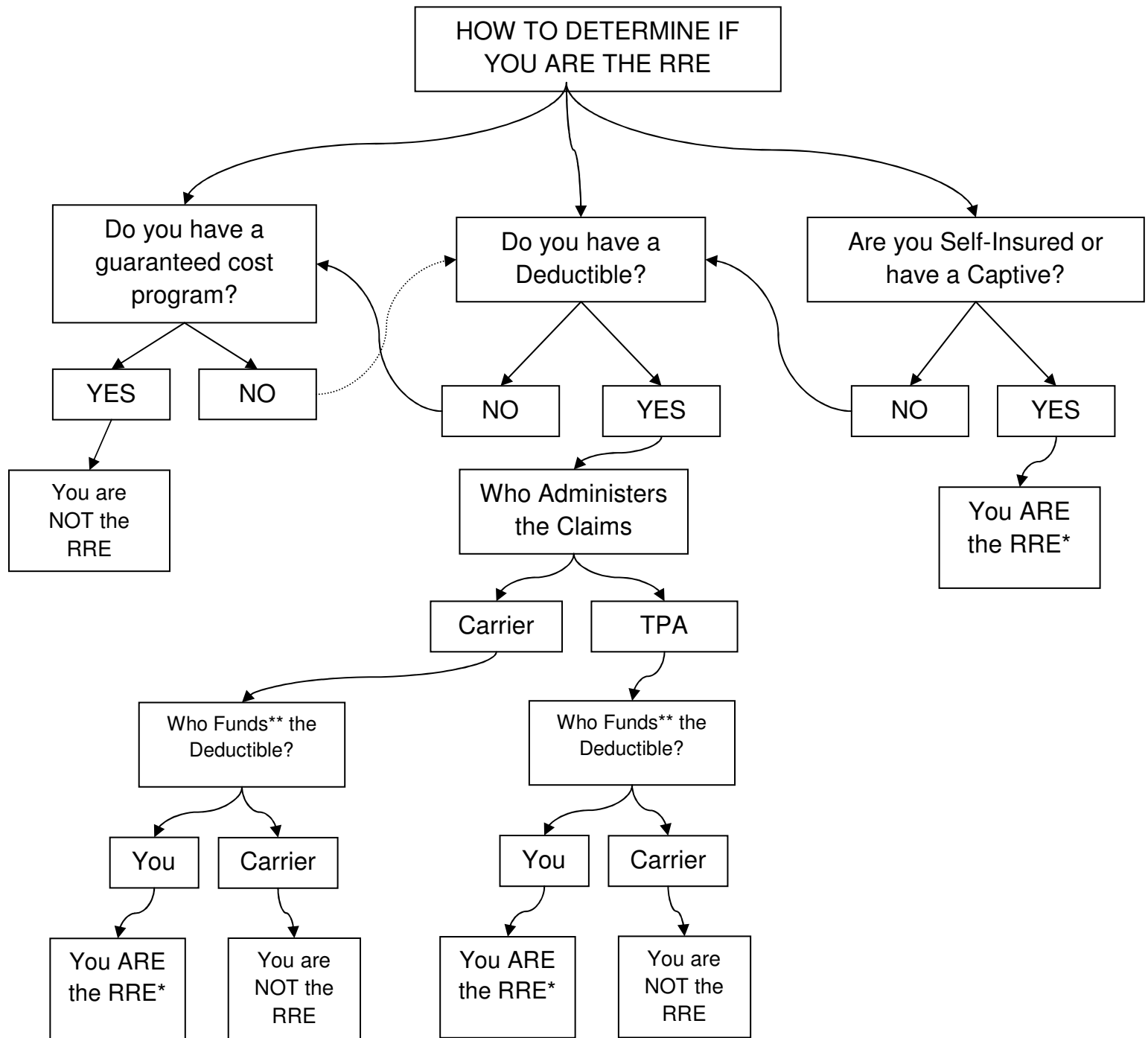
While reviewing the secondary payer issues of GHP programs, CMS became aware of other Non-Group Health Plan (NGHP) programs that may be the primary payers on claims for individuals who are covered by Medicare, Medicaid or the State Children's Health Insurance Program (SCHIP). These NGHP programs were identified as workers' compensation, liability and no-fault insurance. As part of the MMSEA, CMS developed separate guidelines for these programs to report claim activity for affected beneficiaries.

The definition of the Responsible Reporting Entity (RRE) for NGHP programs is the party considered to be the funding source and responsible for payment to the Medicare beneficiary. The rule of thumb for NGHP programs is "follow the money". Examples of NGHP RRE are:

- ◆ Guaranteed Cost Program (similar to fully-insured medical plans) – The carrier is the RRE.
- ◆ Self-Insured or Captive Program –The self-insured employer or captive program is the RRE. Per NGHP provisions, the Third Party Administrator (TPA) for the self-insured or captive program cannot be an RRE.
- ◆ Deductible Program – If the claims are administered by the carrier, and the carrier funds the deductible limit, the carrier is the RRE.
- ◆ Deductible Program – If the claims are administered by the carrier, and the employer funds the deductible limit, the employer is the RRE.
- ◆ Deductible Program – If the claims are administered by a TPA and the carrier funds the deductible limit, the carrier is the RRE.
- ◆ Deductible Program – If the claims are administered by a TPA and the employer funds the deductible limit, the employer is the RRE.

The diagram at the bottom of this article provides a simplified visual representation of the process for determining the RRE for NGHP programs. Always "follow the money".

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*A TPA cannot be a Responsible Reporting Entity (RRE) under Non-Group Health Plan (NGHP)
 ** Funding is defined by Medicare as who pays the claimant (issues the check)

MMSEA of 2007 (cont.)

One of the difficulties faced by NGHP data reporting is that social security numbers (SSNs) are normally available only with workers' compensation claims. Liability and no-fault insurance do not require SSNs in the payment process.

Because workers' compensation, liability and no-fault insurance are not governed by HIPAA it is easier to obtain claim information to submit to CMS. However, other specific state and federal rules may require employers and carriers to maintain individual privacy. All parties must use reasonable efforts to keep individual data secure.

The timeframe for registering as an RRE ended September 30, 2009. This included all companies with self-insured or captive programs or those with deductible casualty programs funded by the employer, per the attached diagram. Employers with fully-insured or deductible insurance programs funded by the carrier were not required to register the RRE, because the carrier is the RRE. Once registered, CMS will provide the RRE with an ID number. This number is required on all Mandatory Insurer Reporting (MIR). "Insurer" means all RREs. Test data feeds to CMS are to be done during the period from January 1, 2010 through March 31, 2010. Actual "live" data feeds and claim reporting will start on April 1, 2010.

Under MIR, on a quarterly basis RREs are required to check Medicare beneficiary status on all claims, report claims involving these beneficiaries, and report settlements, judgments and awards on all claims involving Medicare beneficiaries for workers' compensation, liability and no-fault insurance. While RREs may contract with a vendor to actually transmit the information to CMS, the RRE remains responsible for verifying that the information being transmitted is accurate and timely. CMS may assess a financial penalty of \$1,000 per claimant per day for failing to meet these reporting requirements.

Besides these above noted reporting requirements, it is necessary for the Payers to protect Medicare's interests when settling a claim that will close out future medical care.

Currently, CMS will review settlements of claims under two scenarios. The first is where the claimant currently is a Medicare beneficiary and the total settlement is greater than \$25,000 with a close out of future medical treatment. The second is where there is a "reasonable expectation" of Medicare enrollment within 30 months of any settlement date, and the total settlement for anticipated medical expenses, disability and lost wages over the life/duration of the settlement agreement is expected to exceed \$250,000. For workers' compensation settlements that close out future medical benefits, Medicare's interests on these benefits are allocated to a Medicare Set Aside (MSA). For liability and no-fault settlements that close out future medical treatment benefits, Medicare's interest is allocated to a Claims Settlement Allocation (CSA).

Under MSP statutes for NGHP programs, CMS and the claimant may bring a private cause of action if the primary payer for liability settlements fails to pay or properly reimburse Medicare or adequately protect Medicare for current or future covered expenses. Medicare and the claimant can collect up to double the damages, interest and expenses if litigation is required to pursue recovery.

CLOSING

On a regular basis, CMS is clarifying and revising procedures for obtaining and collecting information under MMSEA. It is important that companies and the employees responsible for overseeing these programs remain current with all changes. This is especially important for those firms where GHP and NGHP programs are handled by separate departments. Communication from CMS does not always clearly identify whether the issue relates to a GHP or a NGHP program. Hays Companies provides updates following CMS scheduled town hall teleconferences.

The financial penalty for failure to comply with reporting requirements is \$1,000 per claimant per day, so understanding the process is critical. The RRE is responsible for paying these penalties. Penalties are not covered under the employer's casualty insurance.



HAYS COMPANIES
IDS Center, Suite 700
80 S 8th Street
Minneapolis, MN 55402

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