Willis HRH

STRATEGIC OUTCOMES PRACTICE

ALERT

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PRIMARY PAYERS BEWARE: MEDICARE REPORTING REQUIREMENTS ARE LOOMING

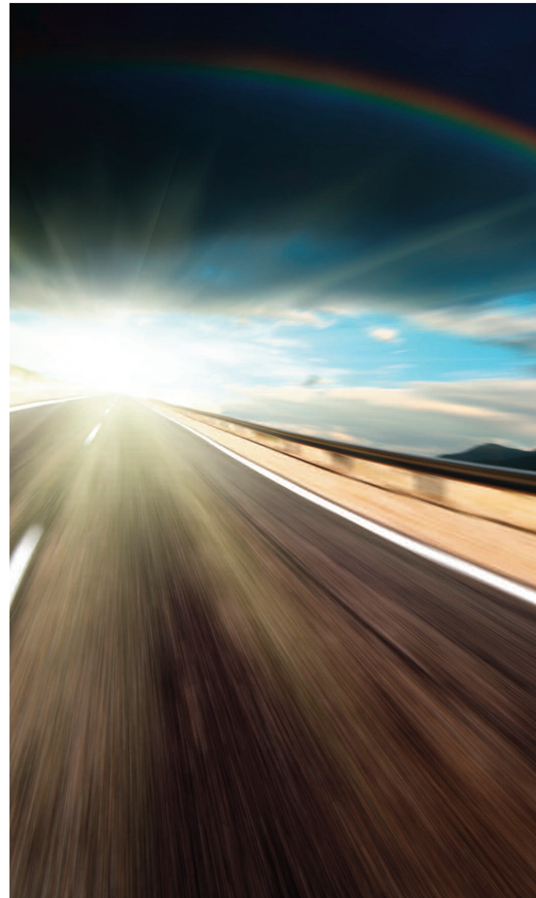
Medicare was established by Congress in 1965 to pay medical expenses for the elderly, disabled and people suffering from end-stage kidney disease. Initially, Medicare paid essentially all expenses for eligible participants. In 1980, however, in an effort to curb unnecessary Medicare payouts, Congress passed the Medicare Secondary Payer Statue (MSP). The MSP was designed to shift costs paid by Medicare to 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 (including self-insurance), no-fault insurance and Workers' Compensation.

With passage of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), Congress updated the rules, and in January 2010, the Centers for Medicare and Medicaid Services (CMS) will require primary payers to comply with regulations that (1) help Medicare recover payments that should have been paid by primary payers; and (2) ensure that any additional medical costs are covered by primary payers, not Medicare. The regulations require primary payers to submit quarterly reports to CMS with detailed information about any claim related to a Medicare beneficiary.

THE EXPANDING REACH OF THE MSP

Section 111 of the MMSEA will have broad implications, including:

- Civil penalties of up to $1000 per day for failure to comply with reporting requirements
- Complication of liability claims settlements resulting in increased litigation
- Reduced opportunities to settle minor claims requiring increased spending for Medicare Set-Aside (MSA) Arrangements



WEBINAR

Willis HRH will host a webinar on April 16, 2009 from 11:30 AM to 1:00 PM EST to discuss this issue. To access the webinar:

URL: https://e-meetings.verizonbusiness.com/nc/join.php?i=PA5991635&p=9180367&t=c

CMS User Guide: http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf

Audio: 888 324 7512
Participant Passcode: 9180367

A replay of this webinar will be available for 30 days after the event at:
https://e-meetings.verizonbusiness.com/nc/join.php?i=PA5991635&p=9180367&t=r

CMS released a Section 111 user guide on March 16, 2009 and will update the guide from time to time. RREs are urged to check the CMS Section 111 web page at: www.cms.hhs.gov/MandatoryInsRep for the latest version of this guide and for other important information.

Accordingly, organizations that provide Liability insurance (including self-insurance), no-fault insurance, and Workers' Compensation to individuals entitled or soon to be entitled to Medicare must be in full compliance with Section 111 by January 1, 2010 to prevent incurring liability pursuant to the MSP.

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 CMS secure website between May 1, 2009 and June 30, 2009. Registration after June 30, 2009 is permissible, but any exposure an RRE may have had prior to registration will not be mitigated. RREs must report quarterly to CMS all claims involving Medicare beneficiaries where payments have exceeded thresholds outlined in the 3/20/09 *Alert* published by CMS. The reporting must be completed within a seven-day period to be determined by CMS. The reporting timeframes are not uniform and a company with coverage from several carriers 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 (no deductible). However, companies with a deductible policy (that do not pay the deductible through a carrier) who handle their own claims, are considered self insured pursuant to Section 111. Such self-insured companies must register and report claims that are within the deductible retention. If the claim exceeds the retention and triggers an excess insurance policy layer, the excess carrier will usually not be the reporting entity unless they take over direct claim payments and adjusting of the claim.

Section 111 permits RREs to designate a third party to report claims. Third-party administrators (TPAs) that manage claims within the self-insured retention and separate companies independent of the TPA can provide reporting services. Before designating an agent, each RRE must register with CMS. The registrant for the RRE must have authority to enter into the agency agreements on behalf of the RRE. An RRE has three options for SCHIP reporting:

- They can choose to be a direct reporting entity to HHS/CMS.
- They can choose to utilize a third-party aggregator to report for them.
- They can designate an account manager (such as a TPA) to be their SCHIP reporting agent.

REPORTABLE CLAIMS

Section 111 mandates that RREs must report all claims in which the claimant is entitled to Medicare benefits above the established thresholds. Many claims will present reporting challenges because the claimants will have to provide information not previously required as part of the claim investigation, including Social Security numbers. CMS requires submission of 131 data elements for each claim that meets the reporting criteria. Section 111 applies to new claims with a loss date after July 1, 2009 and to earlier claims on which payments are made after July 1, 2009. Since the initial act was originally passed in 1980, any open claim with a loss date after December 5, 1980 (or was open on or after that date) and a claimant who is entitled to Medicare benefits, are subject to Section 111 reporting requirements if the claim remains open as of July 1, 2009.

Section 111 reporting requirements were originally scheduled to go into effect July 1, 2009. The period between July 1, 2009 and December 31, 2009 will now be a test phase for the transmission of data from RREs to the CMS. However, CMS is requesting that live data be used during the test phase to ensure that transmissions to and from CMS are working properly. CMS is prepared to accept standard live reporting as of October 1, 2009. RREs must begin submitting actual data in the first quarter of 2010. Failure to comply with the reporting requirements of Section 111 could result in civil money penalties of $1,000 per claim, per day for each day of non-compliance.

CLAIMS SETTLEMENT

Initially, the Section 111 reporting requirements were intended to apply to every Liability claim, regardless of the value. However, a recent CMS alert indicates that an interim threshold for reporting has been established: only those Liability claims with a value of $5,000 must be reported in 2010. In 2011 and 2012, the threshold for reporting will be reduced to $2,000 and $600 respectively.

Implementation of the new rules is expected to complicate the settlement of all Liability claims. Although SCHIP merely establishes claim reporting requirements, the Medicare Secondary Law is also at work here and happens to be administered by CMS – the same entity responsible for enforcing SCHIP reporting. One issue relates to the approval of MSAs by CMS. In the Workers' Compensation context, when a third party investigates a Workers' Compensation claim and determines the amount of money the primary payer should set aside for the ongoing treatment of a covered injury, that amount (the MSA) is subject to approval by CMS. The approval by CMS indicates that all parties to a claim will have the same expectations as to costs for the Workers' Compensation claim. In the case of Liability claim settlements, CMS has no formal pre-settlement approval plan in place for Medicare Set-Aside Arrangements. If a settlement involves both an approved MSA and a Liability amount, it is incumbent on the payer to clearly indicate both amounts, and to explain that the settlement may impact the claimant's ability to collect Medicare benefits. Failure to properly settle claims could create exposure to litigation initiated by the claimant or CMS under the Medicare Secondary Payer statutes.

Perhaps the most significant change will come with regard to settling so-called nuisance settlements for minor injuries. These inexpensive resolutions will be harder to make in cases involving current or soon-to-be Medicare recipients. Such settlements may trigger reporting requirements, which in turn may obligate the RRE to fund MSAs. Funding the MSAs may significantly increase the cost of the claim. In addition, if Medicare takes a hard line on negotiating liens, settlements on cases involving anything but clear liability will also be more difficult.

A similar logic applies to organizations that handle notice-only Workers' Compensation claims or administer small, medical-only payments in-house. If the payment value of these claims exceeds the thresholds established by CMS via the 3/20/09 *Alert*, the payers in these cases will be subject to Section 111 reporting requirements and may need to rethink how these claims are handled. The *Alert* from CMS instructs that payers with ongoing medical payment responsibility (OMR) for claims with less than one week of compensable lost time are not required to report under Section 111. That is, however, subject to change.

A FLUID ENVIRONMENT

As evidenced by the March 20 *Alert* from CMS, this is a very fluid environment and the issues continue to change as the rules are redefined. We expect many more updates between now and the inception date. The Willis HRH team monitoring this matter will continue to provide updates as necessary.

CONTACT

For additional information on this topic or about the webinar, please contact:

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