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What You Need to Know about the New Medicare Reporting Requirements

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Overview of MMSEA Section 111

Medicare, Medicaid and SCHIP Extension Act of 2007

- Opens unprecedented dialogue between Medicare and liability insurers (including self-insured entities) and no-fault insurers
- Mandates these entities and workers' compensation insurers report
 - Resolution of most claims involving bodily injury, including payment of ongoing medicals, to Medicare beneficiaries
 - Electronically, on a quarterly basis, commencing the 2nd quarter of 2010
- Group health plans (GHPs) have similar reporting obligations under different section of Act; above entities known as "non-GHPs" or "NGHPs"

Genesis of Section 111 Reporting

- Medicare pays health care provided to enrolled individuals age 65 and older, certain disabled individuals and those with permanent kidney failure
- Act seeks to enforce payment obligations of non-GHPs that have existed under the Medicare Secondary Payer (MSP) Statute since 1980
 - To pay primary to Medicare for bodily injuries
 - To reimburse Medicare for "conditional payments"
 - Made by Medicare pending resolution of a non-GHP claim
 - Or when Medicare was unaware another payer had primary payment obligations

Genesis of MMSEA Section 111 Reporting

- Centers for Medicare & Medicaid Services (CMS) needed new regulatory powers
 - Limited agency resources focused previously on GHP recoveries
 - CMS required new sources of claims information
 - Voluntary reporting wasn't capturing sufficient portion of 3 million claims filed annually by Medicare beneficiaries against non-GHPs
 - Stiff monetary penalties thought to better motivate insurer reporting
 - \$1,000 per day
 - Per Medicare beneficiary whose claims are not reported

Who's Required to Report?

- “Responsible reporting entities” (RREs)
 - For non-GHP reporting, RREs are the “Applicable Plans” as defined by Medicare:
 - Liability insurance plans, including self-insurance
 - No fault insurance plans
 - Workers' compensation laws or plans
 - “An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance or otherwise) in whole or in part.” (MSP Regs)
 - TPAs cannot be RREs for non-GHPs

Who's Required to Report?

- Special RRE Rules
 - Deductibles: If entity is self-insured for a deductible but pays deductible to insurer and insurer pays claimant, insurer is RRE
 - Excess carriers
 - Key to RRE designation
 - Who pays claimant?
 - If self-insured entity pays claimant, and excess carrier reimburses self-insured for any payment above retention, then self-insured entity is the RRE
 - Typical AEGIS members are RREs and must report claims payments below and above retention limit

Who's Required to Report?

- Similar “who pays claimant” rule for reinsurance, stop loss insurance, umbrella insurance, guaranty funds and patient compensation funds
- WC: self-insured employer, employer's insurer or government agency is RRE
- Fronting arrangements: entity that assumes financial risk for claim is RRE
- Self-insurance pools, not members, may be RREs
 - If the self-insurance pool
 - Is a separate legal entity
 - With full responsibility to resolve and pay claims using pool funds
 - Without involvement of the participating entity

Who's Required to Report?

- RRE must register with COB Contractor (COBC) by Sept. 30, 2009
 - Will be assigned one or more ID numbers as requested; no limit; need one ID for each Claim Input File (which is made up of multiple claims records)
 - Must designate “Authorized Representative” and “Technical Contact”
 - May appoint agent(s) for actual reporting, but RRE remains solely responsible for Section 111 compliance and accuracy of reported data
 - CMS suggested agents: data service companies or consulting companies
 - Use same agent for WC and liability claims reporting?
 - Agent cannot register RRE

Coming into Compliance: Timeline for Registration, System Development, Testing and Reporting

- Phase 1 Development period
(prior to registration)
- Phase 2 Registration period
(May 1, 2009 - September 30, 2009)
- Phase 3 Testing period for Query Input Files
(July 1, 2009)
- Phase 4 Testing period for Claim Input Files
(January 1, 2010 - March 31, 2010)
- Phase 5 Reporting begins for Claim Input Files
(April 1, 2010 - June 30, 2010)

When Is the Section 111 Reporting Obligation Triggered?

- Two reporting scenarios
 - Total payment obligation to claimant (TPOC)
 - Claims resolved (fully or partially) through a settlement, judgment or award
 - On or after January 1, 2010 with a single payment obligation
 - Ongoing responsibility for medicals (ORM)
 - Claims for which, as of July 1, 2009 or later, RRE has an obligation to make
 - If claimant is not a Medicare beneficiary, RRE must report claims if individual becomes a Medicare beneficiary, unless payment responsibility has terminated
- Prior notice to CMS is not a substitute for Section 111 compliance

Reporting Thresholds

- Two categories of interim dollar thresholds reduce reporting for some RREs
 - ORM
 - Self-insured plans have no de minimus dollar threshold
 - Report all claims accepting *any* responsibility for payment of covered services
 - TPOC (multiple TPOC claims for one beneficiary must be combined)
 - 2010: report claims over \$5,000
 - 2011: report claims over \$2,000
 - 2012: report claims over \$600

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Reporting 101

What specific claims data must be reported?

- Over 100 data fields per claim record
- Identity of injured party (arguably most important)
 - Request Medicare health insurance claim number (HICN) or SSN from claimant if not known
 - Claimants are refusing to disclose
 - Safe harbor available if send model CMS language to claimants (under development) and get no response
 - Risks a bad faith claim by claimant?
 - COBC will not accept claim if HICN or SSN is missing; keeps no record of claims it returns to RRE

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Reporting 101

What specific claims data must be reported?

- Can query Medicare COBC to learn if individual is a Medicare beneficiary
 - But only one query per month per RRE ID (need SSN or HICN to query)
 - One query can cover multiple individuals
 - Medicare provides HIPAA eligibility wrapper software
- Or report claims data for each individual in Medicare age bracket, shifting burden to CMS to make Medicare beneficiary determination (still need SSN)

Reporting 101

What specific claims data must be reported?

- Claimant (if not the injured party)
- Attorney for claimant or injured party
- Plan / insurance type and policyholder
- Date of incident
- Claim resolution (how resolved – ORM or TPOC – and \$)

Reporting 101

When must RREs report?

- Beginning in 2nd quarter of 2010
- Over a 7-day submission period
- Assigned by COBC
- Date of settlement, judgment or award triggers first reporting obligation
- Necessary to promptly (next quarterly submission) update, correct or delete submitted and accepted records
- Do not report each time a payment is made

Reporting 101

How does an RRE report?

- Through electronic file exchange
- One “Claim Input File” per quarter per RRE ID
- May request unlimited RRE IDs to better manage reporting
 - Per claims system, e.g., WC and no-fault claims
 - Per line of business
 - Per legal entity (subsidiary or division)
 - At anytime after initial registration
- COBC returns a Claim Response File for each Claim Input File with disposition and error codes and compliance flags

Reporting Challenges and Headaches

- Collecting SSNs and HICNs
- Locating required data – do you have it?
- Must you take affirmative steps to gather data you don't have?
 - CMS assistance with form letters to claimants
 - Medicare beneficiaries who do not provide requested information may be violating obligations to assist Medicare in coordinating benefits (per CMS)
- Imprecise, inconsistent and evolving CMS guidance
 - Public town hall teleconferences
 - CMS Mandatory Insurer Reporting website, with link to non-GHP “User Guide”
 - No regulations – what deference does a court owe this guidance?

Sanctions for Noncompliance

- \$1,000 for each day of noncompliance
 - For each individual, for whom claims information should have been reported
 - How calculated? Mitigate daily penalties by making submission before next quarter?
 - Unreasonable without safe harbors or mitigation opportunity
- Only one narrow safe harbor (sending out CMS “model language” to Medicare beneficiaries to collect SSNs)
- Recommend documenting implementation, testing efforts, transmissions, and claimant correspondence
- CMS: Our primary interest [today] is collecting data, not penalties, and assisting plans in establishing compliant reporting systems

Unanswered Questions

Reading between the lines of CMS guidance

- Coordinating with other insurers: Who reports? Who has the data?
 - Mass torts litigation (CMS working group invitation)
 - Liability pools
- Reporting by overseas insurers – extraterritorial application of Section 111
 - Long-standing presumption against such application
 - Informal CMS guidance appears to ignore presumption
 - Requires overseas insurer to report under certain unidentified scenarios
 - Geographic location of incident, illness or injury is not determinative of reporting obligation, per CMS, as Medicare beneficiaries can return to States for services

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After the Report Is Filed

Liability under MSP law

- Collection of claims data will undoubtedly lead to an increase in CMS recovery actions for Medicare overpayments
- Non-GHPs must pay primary to Medicare – cannot supersede federal law
- CMS has both a direct right of recovery and subrogation rights
- If Medicare makes conditional payments, can recover from entity *or* individual that receives payment from the primary payer *or* from the non-GHP
 - Under Medicare regs should look first to beneficiary, beneficiary's counsel or provider
 - But MSP statute does not require this

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After the Report Is Filed

Liability under MSP law

- What portion of settlement, judgment or award can CMS take to recoup a conditional payment?
 - CMS is not bound by parties' determination of liability or allocation of settlement, even if court approved
 - CMS must respect special verdicts
- Potential for duplicative payment and triple payment by primary payer
- Limitations on Medicare recoveries
 - Medical claims paid after settlement, judgment or award
 - For liability claims where date of incident was prior to Dec. 5, 1980, or no exposure on or after Dec. 5, 1980

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Looking Ahead

- Can AEGIS members protect themselves by
 - Communicating early with CMS?
 - Use of notices to limit liability for Medicare recoveries
 - Section 411.25 notices
 - Advance notice pending judgment or settlement
 - Requesting Medicare payment information through claimant?
- Should you seek judicial determination of your reimbursement liability?
- Which statute of limitations applies?

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Looking Ahead

- Waiting for Medicare's interest: Is there a potential conflict with state claims handling and prompt payment laws?
- Does MSP law preempt the collateral source rule?
- Do constitutional constraints and defenses offer any protection against duplicative payments?
- Does the plain language of the MSP Statute reach liability insurers who owe contractual obligations to insureds to pay damages but have *no obligations* that run directly to Medicare beneficiaries to pay their medical costs?

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