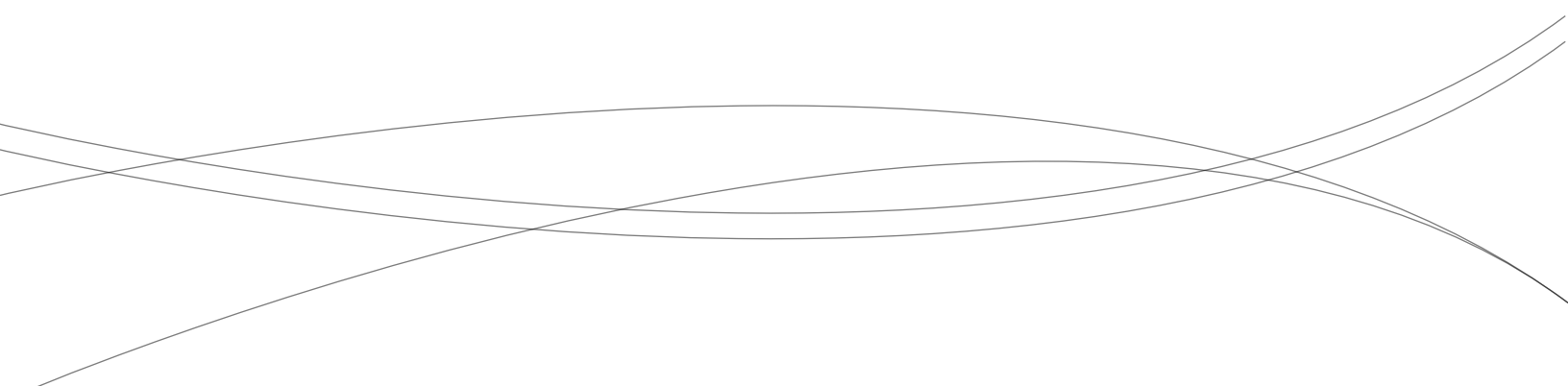


Changes to the Medicare Secondary Payer Statute (MSP) Create New Risk Exposures for Businesses



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New requirements become effective July 1, 2009 for claims pertaining to liability insurance (including self-insurance), no fault insurance and workers' compensation claims with ongoing medical responsibilities. (For group health plans*, the implementation date was January 1, 2009.) All RREs are required to submit their first Claim Input data during their assigned timeframe, which will range from January 1 through June 30, 2010.

There are a number of risk implications of Section III of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 that are related to liability insurance, self-insurance, no-fault insurance, workers' compensation and group-health plans.

BACKGROUND

Since the Medicare Secondary Payer Act (MSP) became law in 1980, Medicare has been a secondary payer when another primary source of coverage is available with respect to liability insurance, self-insurance, no-fault insurance and workers' compensation. The statute is intended to shield Medicare from certain medical expenses when other parties bear primary liability for such costs.

In 2003, the Medicare Prescription Drug Improvement and Modernization Act expanded Medicare's ability to enforce the MSP. Through the Center for Medicare and Medicaid Services (CMS), Medicare was given the ability to seek recovery "against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received any portion of a third party payment directly or indirectly," if the funds were part of a settlement involving a primary insurer.¹

The MSP statute has helped CMS save \$6 billion annually, and avoid recovery costs by ensuring CMS does not pay claims for which another entity is the primary payer. However, CMS has never had systems in place to monitor compliance with MSP provisions.

MEDICARE, MEDICAID AND SCHIP EXTENSION ACT OF 2007 (MMSEA)

With the passage of the MMSEA in 2007, CMS announced new reporting mandates for liability insurance, self-insurance, no-fault insurance and workers' compensation plans. Responsible Reporting Entities (RREs) must regularly transmit electronic claims data to CMS for the purpose of coordination of benefits. The MMSEA essentially makes the RREs responsible for identifying claimants who may receive payments from Medicare,

and reporting any settlements, awards or judgments to CMS that involve someone who is eligible for Medicare. The Act shifts responsibility for determining if there is a primary source of payment other than Medicare from CMS to the liability insurer, self-insurer, no-fault insurer and workers' compensation insurer.

PENALTIES FOR NON-COMPLIANCE

The penalty for non-compliance with the MMSEA is \$1,000 per day, per reportable Medicare claim. Medicare anticipates collecting more than \$1 billion in non-compliance fines to fund the State Children's Health Insurance Program (SCHIP).

RESPONSIBLE REPORTING ENTITY (RRE)

One of the keys to complying with the MMSEA is to determine whether your company meets the definition of an RRE. RREs include insurers and self-insurers who carry their own risk, in whole, or in part through deductibles and self-insured retentions. (Note: CMS and the insurance industry rely on different definitions of "self-insurance.")

Third party administrators (TPAs) cannot be RREs. An RRE may contract with a TPA to act as the reporting agent on behalf of the RRE, but the RRE remains responsible for the results.

Reporting requirements for RREs are extensive. As a result, insurers, self-insurers and TPAs are modifying their claim processing systems to capture and report data elements not previously collected.

DEFINING A REPORTABLE CLAIM AND TESTING

An RRE must report claims where the injured party is a Medicare beneficiary and there has been a settlement, judgment, award or other payment. This reporting obligation is usually triggered by liability claims that occurred on or after January 1, 2010.

An RRE must also report claims where there is no settlement, judgment, award or other payment, but the RRE has assumed ongoing responsibility for medicals associated with the claim for

¹ 42 CFR 411.24(g)

GENERAL CRITERIA FOR DETERMINING THE RRE FOR YOUR ORGANIZATION:

Type of Insurance Program	Responsible Reporting Entity
Fully insured guaranteed cost or retrospectively rated program	Your insurance carrier
Insured program with a deductible	<ul style="list-style-type: none">Your company for payments you make to the claimant or for payments you reimburse to a third party administrator who makes payments on your behalf.The insurance carrier for payments the insurance carrier makes to the claimant or that the insurance carrier reimburses to a third party administrator.
Self insured	Your company
Insured program with a self-insured retention	Your company, for payments made within the self-insured retention
Self-insurance pool or captive and the pool or captive is a separate legal entity with a full authority to resolve and pay claims using pool funds without involvement of the participating employer	The self-insurance pool

the injured party, usually triggered by workers' compensation or no fault claims that are retroactive to July 1, 2009, if they remain open on January 1, 2010.

Testing for mandatory reporting will begin on July 1, 2009 and continue through March 31, 2010. Data reporting will go live January 1, 2010, yet RREs must report retroactively to July 1, 2009.

RREs who have completed testing can submit their first Claim Input production files during their assigned timeframe, which will be sometime between January 1, 2010 and March 31, 2010. Also, between January 1, 2010 and June 30, 2010, all RREs will submit their first Claim Input production files during their assigned timeframe.

REGISTRATION

If your company is an RRE, you must register on the Coordinator of Benefits Secure Website (www.section111.cms.hhs.gov) between May 1, 2009 and September 30, 2009.

Registration must be done by an authorized representative of your company who has legal, binding authority and ultimate accountability for compliance. This responsibility cannot be delegated to a third party. However, as indicated above, a third party may act as your agent to provide the required reports to CMS.

WHAT TO DO

If you are insured under a traditional guaranteed cost or retrospectively rated insurance program, your insurance carrier is the RRE and will handle all aspects of MMSEA reporting. The same is true if you are insured under a deductible program where the insurance company makes all initial payments to the claimant.

If your company qualifies as an RRE, you must immediately register on the Coordinator of Benefits website. Kibble & Prentice recommends you consider contracting with a TPA or other reporting provider to act as your reporting agent. While Medicare will still consider your company primarily responsible for any fines and penalties resulting from non-compliance, you may be able to transfer some exposure to the reporting agent through a contract with strong defense and indemnification language. Please contact your Kibble & Prentice Account Executive to discuss available options.

USEFUL LINKS

www.section111.cms.hhs.gov (for RRE registration)
www.cms.hhs.gov/MandatoryInsRep/ (CMS's Overview of MSP Reporting)
www.marccoalition.com (Medicare Advocacy Recovery Coalition)

* For more information on how MMSEA applies to group health plans, refer to Kibble & Prentice's "Friday Footnote" from March 6, 2009 and the Technical Bulletin from October 24, 2008, available at kpc.com or by contacting your account executive.

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