



Understanding the Medicare, Medicaid and SCHIP Extension Act of 2007



CNA believes we are more than your underwriting and risk management provider. Our ongoing customer service, technical support, and consultative services allow us to be your long-term partner for a variety of business needs, including helping you navigate the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) and its Section 111, entitled “Medicare Secondary Payer (MSP) Mandatory Reporting.” This document clarifies the most important aspects of the MMSEA as they relate to nongroup health plans, identifies areas where businesses can expect significant impact, and describes appropriate strategic responses your company may wish to consider.



SUMMARY OF MEDICARE, MEDICAID AND SCHIP EXTENSION ACT

What is the Medicare Secondary Payer Act?

In 1980, the Medicare Secondary Payer Act (the MSP) was enacted to amend the Social Security Act, representing an effort to reduce federal health care costs. MSP prohibits Medicare from reimbursing for medical benefits where "payment has been made or can reasonably be expected to be made" under a workers' compensation law, or other private insurance plans. As a result, Medicare was no longer a primary payer for a Medicare beneficiary's medical costs.

What is Section 111 of the Medicare, Medicaid & SCHIP Extension Act of 2007?

As of January 1, 2009, Section 111 adds mandatory data reporting requirements for nongroup health plans, such as liability insurance (including self-insurance), workers' compensation and no-fault insurance plans.

Insurers providing these products must report claim information involving a Medicare beneficiary claimant (a) where an ongoing responsibility for medical payments exists as of July 1, 2009, and (b) where the settlement, judgment or award date is on or after January 1, 2010. Failure to comply with these requirements can result in civil penalties of \$1,000 per day, per claimant.

Historical Perspective

Medicare was created when the Social Security Act of 1965 became law. It is a federally funded health care, hospitalization, and prescription drug program for qualified beneficiaries, including individuals age 65 or older, those younger than age 65 with certain disabilities, and individuals of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or transplant). The State Children's Health Insurance Program (SCHIP) provides matching funds to states, and is designed to provide health insurance coverage for uninsured children in families not qualified for Medicaid.

Protecting Medicare's Interests

For a number of years, many insurance companies, including CNA, have been working with the CMS to obtain approvals for Medicare set-asides on qualifying workers' compensation settlements. Now, insurers and businesses must update the amount of claimant information being reported to the CMS, as well as broaden their reporting scope to include liability insurance claims (including self-insurance arrangements) and no-fault insurance claims. The information will be used to identify Medicare beneficiaries as early as possible. Having the data will help ensure benefit payments are made according to MSP protocols; help reduce the volume of overpayments and underpayments; and better support the recovery of mistaken or conditional payments. CNA is fully cooperating in this effort to help protect Medicare's interests before, during and after a settlement.

These new requirements reinforce the goals of the MSP statute, supporting Medicare's ability to:

- avoid making initial payments
- seek repayment of conditional payments already made by Medicare
- require set-asides for the payment of a claimant's or a covered individual's future medical expenses

Under Section 111, insurers must (1) determine whether an injured claimant is a Medicare beneficiary; and if so, (2) submit additional information for that claimant via a quarterly secure electronic data interface.

The Centers for Medicare & Medicaid Services (CMS) is the federal agency in charge of the administration of Section 111. Each quarter, it will review and validate all data transmissions received from insurers. These transmissions are being referred to variously as 'Claim Input Files,' 'Mandatory Insurer Reports,' or 'MIRs.' The CMS will also issue and collect all fines.



IMPACT TO YOUR BUSINESS

Complying with Section 111 and CMS guidelines may require your company to introduce new policies, change internal business practices, or enhance technical functionality within your data management systems. In order to remain compliant, your company should focus on the quality of the claimant data you collect, analyze, and submit electronically to the CMS — and be sure that all electronic transmissions occur on or before the dates mandated.

CMS Timeline

As of this writing, the CMS has published this amended timeline of important dates:

May 1, 2009 - September 30, 2009	Registration period for Responsible Reporting Entity (RRE)
July 1, 2009	RREs start collecting Medicare beneficiary data
July 1, 2009	CMS accepts Query Input Files from properly registered entities
January 1, 2010	CMS begins testing the transfer/receipt of Claim Input Files
January 1, 2010	Production Claim Input Files will be accepted by the CMS
April 1 – June 30, 2010	Period during which Claim Input File submissions will be due

Please Note: All milestone dates within the current timeline are subject to change by the CMS.

Unchanged Regulations

Section 111 does not change or eliminate existing statutory provisions, regulations or processes related to the MSP, including:

- *Policies and methods for protecting Medicare's interests regarding claim settlements and Medicare set-asides*
- *Policies and methods for identifying private insurance plans responsible for primary payments of a beneficiary's health care, or Medicare's reimbursement rights for payments it has made; or,*
- *Policies and methods for assisting the CMS in recovering conditional payments it may make*

Responsible Reporting Entity Obligations

Entities which fund insurance plans and make payments to claimants are to be considered a RRE, and are mandated to comply with Section 111 reporting requirements.

Whether CNA, our clients, and/or third parties have reporting responsibilities under Section 111 is determined primarily by the specifications of any given insurance plan or coverage arrangement. CNA will work with you and your legal representatives to clarify reporting responsibilities, especially when plan details are unique. The following table (pg. 4) illustrates a general understanding of reporting obligations by common plan types.

On your behalf, CNA will report all mandatory data pertaining to Medicare beneficiary claimants involved in personal injury or workplace injury (hereafter, "injury") claims handled and paid directly by us.

Where CNA handles only the processing of your claims, we will support you in your RRE role, by serving as your designated agent for reporting purposes.



When you assign the administration of your claims internally (i.e., self-administration), you have all reporting obligations. When you contract with a third-party administrator (TPA) to process your claims, the TPA serves as your agent for reporting purposes. CNA would have no reporting responsibilities.

For our self-insured clients who are the RRE, CNA can be designated as an agent for reporting purposes. However, when those clients contract with TPAs, the individual TPAs are typically designated as the reporting agent. In such scenarios, CNA will have no reporting responsibilities.

INSURANCE PLAN OR POLICY TYPE	RRE OBLIGATION
Retrospective Plans	CNA
Large Deductible Plans	CNA ¹
Self-Insured Retention Plans	Insured ²
Fronted Programs or Captives	Insured
Unbundled Plans	Insured
Guaranteed Cost	CNA
Commercial Protection and Indemnity (for claims <u>under</u> settlement thresholds)	Insured
Commercial Protection and Indemnity (for claims <u>over</u> settlement thresholds)	CNA
Excess, Umbrella, Stop Loss, Ceded Reinsurance, etc.	See Details ²

¹When clients are funding their own losses and claims are handled by a TPA (over which CNA has no direct oversight or management role), the insured is the RRE.

²Depending on the specifications of a given policy, either CNA or the insured could be the RRE.

We are advising our clients to understand their reporting responsibilities, as well as those of their designated reporting agents, and to begin the registration process as soon as possible.



Registering as the RRE

The CMS has selected a Coordination of Benefits Contractor (COBC), to administer a Coordination of Benefits Secure Web site (COBSW) where all RREs must register. In order to successfully complete the process, each of the following steps must be accomplished by the RRE:

- 1 Appoint an Authorized Representative and Account Manager.
- 2 Register on the COBSW page (details on pg. 7). Note: a tax identification number (TIN) for the RRE is required. Following registration, the CMS will issue the RRE ID and a personal information number (PIN). All registration information will be then mailed to the Authorized Representative.
- 3 Using this information, the RRE's Account Manager will complete the process of creating the RRE account on the COBSW, including registering Account Designees, as needed (e.g., COBSW end-users).
- 4 Upon completion of the account creation, the COBC will mail a profile report to the Authorized Representative, who must then review, sign, and return a copy to the COBC.
- 5 The COBC will then e-mail the Authorized Representative and the Account Manager, instructing them as to when electronic data transmission testing can begin.

The key to the registration process is working in a timely manner. Begin this process early, in advance of the September 30, 2009 deadline. Based on the variety of coverage plans and types of policies that may be involved, CNA anticipates some of its clients will require more than one RRE ID. Sufficient time should be allocated for the CMS to issue RRE ID numbers and PIN numbers, considering the total number of RREs nationally. Please note that RREs are unable to complete the final stages of their registration process until they receive their ID numbers from the CMS. And finally, sufficient time must also be reserved for RREs to register their designated reporting agents.

Data Collection & Reporting

CNA is reviewing all injury claims to determine whether they involve a claimant who is already a Medicare beneficiary, or may be eligible for Medicare. These claims are being further evaluated to determine which must be reported to the CMS. For such reportable claims, additional claimant information must be captured in order to make the claim record complete:

- Full Name
- Gender
- Date of Birth
- Social Security Number (SSN), and/or
- Health Insurance Claim Number (HICN), issued to beneficiaries by Medicare

All claimant data is validated before data records are transmitted to the CMS each quarter. Again, RREs must comply with all reporting requirements or be subject to civil monetary penalties.

The CMS recognizes individuals may hesitate or refuse to provide their Social Security Numbers (SSNs) as a result of the new data collection requirements. The CMS also acknowledges that requesting SSNs for the purposes of coordinating Medicare benefits is a 'required and legitimate use' of the SSN under state and federal privacy laws.



Managing RRE Accounts

According to the CMS, there is no limit to the number of RRE ID numbers that can be requested; however, for each ID, the CMS will expect a separate report every quarter.

It is very important to note that the RRE may delegate reporting responsibilities to a designated agent. Ultimately the RRE remains responsible for the accuracy of all data, and accountable for all reporting obligations. Each designated agent will be assigned an ID number associated with their RRE's account. An agent may be an industry TPA or other vendor (e.g., a data aggregation service, consultant, etc.), specifically contracted by the RRE to report claim information. The RRE will be held liable for any penalties due to noncompliance.

The CMS requires each RRE to identify personnel to fill these key roles:

Authorized Representative – An executive level employee (with the legal authority to bind the organization by contract, making it ultimately accountable and responsible for Section 111, MMSEA obligations), who will oversee the data quality/reporting effort.

Account Manager – An employee (or agent) assigned to manage the effort, and have administrative control over the RRE's CMS account. The Account Manager will be the main contact for the CMS, and have access to the CMS secure web site. He or she may name support personnel as account designees.

NEXT STEPS

Monitor CMS Direction

At its discretion, the CMS may continue updating or revising its guidelines as set forth in the CMS User Guide. These activities may result in procedure or timeline changes. Accordingly, CNA will continue monitoring all CMS updates and alerts. We currently review all publically available CMS alerts, participate in all national conference calls and CMS Town Hall Meetings, as well as send CNA representatives to CMS conferences. When directional changes require additional action, we will help clarify those details for you and offer any additional support warranted.

Execute a Strategic Plan

Early in 2008, CNA began executing our strategic plan in response to Section 111. To date, we have updated our claim handling processes, enhanced our automated systems, and launched a comprehensive training curriculum. We have already begun collecting and monitoring the quality of Medicare beneficiary claimant data. Our query process that will compare claimant data against the CMS database is scheduled to initiate testing in early November. And finally, our data transmission capabilities will be available in early 2010. Our efforts will be ongoing, as needed, to ensure compliance with federal requirements.

Provide Customer Service

CNA Client Services resources are proactively fielding and answering your questions. Please continue to consult with your CNA representative to investigate and address any policy review details you may have, or to clarify any RRE-related role or responsibility scenarios defining your business portfolio.



Links To More Information

CMS Medicare home page: www.cms.hhs.gov/home/medicare.asp

CMS Mandatory Insurer Reporting: www.cms.hhs.gov/MandatoryInsRep

MMSEA Section 111 - Medicare Secondary Payer Mandatory Reporting User Guide (May 22, 2009):
www.cms.hhs.gov/MandatoryInsRep/Downloads/GHPUserGuideV2.3.pdf

Coordination of Benefits Secure Web site: www.section111.cms.hhs.gov/MRA/Login.action

CNA Support

Client Services: Bill Molkenbur, 1-973-540-3669, or william.molkenbur@cna.com
[Questions regarding individual policy details, RRE/Agent reporting responsibilities, etc.]

CMS Account Manager: Karen Kerstein, 1-312-822-7028, or karen.kerstein@cna.com
[Questions regarding CNA's RRE account, coordinating registration details, CMS news alerts, etc.]

Outsourced Claim Services: Sarah Condon, 1-312-822-1848, or sarah.condon@cna.com
[Questions regarding agreements involving TPAs, or their reporting responsibilities, etc.]

Medicare Reporting Project Team: MedicareReporting@cna.com
[General comments or questions regarding CNA's MMSEA response effort, etc.]

