

Medicare as a Secondary Payer

New Mandatory Reporting Requirements in Effect (SCHIP Extension Act of 2007)



Overview

Medicare has been the secondary source of payment for a Medicare beneficiary's medical items and services since 1980, when the Medicare Secondary Payer statute was enacted. The primary payers are normally workers' compensation insurers and virtually all other private insurers. Historically, Medicare has been unable to consistently identify primary payers. In an effort to address this, Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was passed on December 29, 2007, adding new mandatory reporting requirements for group health plan (GHP) arrangements and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation (NGHP). The Act also:

- reinforces Medicare's status as secondary payer;
- contains a \$1,000 penalty per day, per file, for not reporting (deposited into Medicare Trust Fund);
- does not eliminate any existing statutory provisions, regulations or processes under the Medicare Secondary Payer Statute (MSP) (42 U.S.C. 1395y).

Reporting Requirements

The Centers for Medicare and Medicaid Services (CMS) require that Responsible Reporting Entities (RREs) report specific information that provides for the coordination of pre-payment and post-payment benefits involving Medicare beneficiaries. Reporting is necessary when:

- there has been a settlement, judgment, award or other payment made to a Medicare beneficiary; or
- there is the assumption of ongoing responsibility for medical costs to a Medicare beneficiary.

The RRE is an entity that contractually or legally assumes the risk for the accident or injury. Medicare defines "Responsible Reporting Entities" (each an "RRE") as the following:

- Group health plan carriers (GHP)
- Non-group health plan carriers (NGHP), including self-insured entities; liability, workers compensation and no fault carriers
- Self-insured entities managing liability, workers compensation and no fault claims

The determination of RRE status is currently a grey area, but there appears to be (unofficial) consensus that it is driven by the specific funding arrangement of the losses.

Timeline to MMSEA Section 111 (revised on May 12, 2009)

May 1, 2009 – September 30, 2009	Electronic registration period for RREs
January 1, 2010 – March 31, 2010	Data testing period with CMS and RREs
April 1, 2010	RREs will submit their first production data to CMS
Ongoing from April 1, 2010	RREs continue submission of data on designated quarterly frequency

Basic Considerations

- First and foremost, determine if you are an RRE (Responsible Reporting Entity). Consider all of the funding arrangements within your casualty program(s). You may be self-insured and/or self-administered in only one state or for a particular category of claims. Examine your current and former program structure(s) carefully.
- If it is determined that you are the RRE, how will you satisfy the data reporting requirements? Will your TPA and/or a designated agent handle that for you?
- Do you have access to the social security numbers of the potential Medicare payees?
- What hold harmless arrangements are in place with your TPA and/or reporting agent and are you adequately protected?

Contact Us

If you would like to learn more about this law, please see the attached overview "Introduction to Section 111 Mandatory Medicare Secondary Payer Reporting" (02/23/09). We would also be pleased to provide additional information. Feel free to contact your Integro broker, or one of the following individuals:

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