Mandatory Insurer Reporting for Property and Casualty Insurers

On 12/29/07 President George Bush signed into law **The Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Extension Act** putting teeth into enforcement of existing regulations but also expanding the scope of enforcement. It shifts much of the burden of protecting the interest of Medicare to self-insurers, group health plans, non-group health plans, liability insurers and attorneys representing plaintiffs and defendants**. The Act under 42 U.S.C. 1395y (b) (7) & 8 effective 7/1/09 requires both GHP (Group Health Plans) and NGHP (Non-Group Health Plans) to determine the Medicare eligibility of claimants and report to Medicare on ALL claims involving Medicare eligible claimants. It requires submission via electronic data interchange (EDI) starting in 2010 and imposes a penalty of $1,000.00 per day, per claim for any claim not reported to Medicare as required.**

Clearly, the intent is to systemically capture data to quantify leakage and maximize recovery. The Congressional Budget Office has predicted that following implementation, Medicare will recover over a billion dollars in fines in the first five years.

In essence, Each RRE (Responsible Reporting Entity = carrier or Self Insured Entity) must register, setup an account with the COBC (Coordination of Benefits Company) and appoint an Account Manager. No agent or TPA may register as a RRE. The RRE will either commit to self reporting or appoint a reporting agent. After successful testing of EDI (Electronic Data Interchange) test files, the COBC will assign each RRE a quarterly report schedule. CMS (Center for Medicare and Medicaid Services) continues to clarify the definition of an RRE as every claims situation does not fit a single mold. Should you have questions concerning your situation, you should contact CMS at 646-458-6740 for direction. CMS has published a User Guide and will release amended User Guide's as necessary on the CMS website **www.Section111.cms.hhs.gov**

***Following is a simplified explanation of the process and then a table with required completion dates*:**

1) **Each RRE must submit a *Claim Input & TIN reference file quarterly*** within the date range determined by the COBC. This report identifies claims involving Medicare beneficiaries and all parties against which Medicare could have an actionable claim (RRE/Claimants/Carriers) including diagnosis codes, claim amounts, TAX ID numbers, settlements/orders....It is a fresh record each quarter - not to include previously submitted/accepted records but will include additions/updates/deletions. Your quarterly updated transmission files must contain a corrected resubmission of any records found in error on the previous file. *No interim file submissions will be accepted.* If the RRE has no new records or information, the RRE still has to submit an "empty" claim input file.

2) **COBC sends a *Claim Response File within 45 days***. It will confirm the data and include rejection error notices if a record fails, provide the HICN (Medicare Health Insurance Claim Number) if the data matches a Medicare record, as well as an indication if a party does not appear to be a beneficiary. It will also include any compliance flags.

3) **Each RRE or their reporting agent may send a *query input file once every calendar month*** with claim records that the COBC will check against the Medicare database to determine if parties are

Medicare beneficiaries based upon data provided but there is no safe harbor if a claimant is not identified as a Medicare beneficiary but benefits are paid out by Medicare thereafter. The RRE is still responsible for the Medicare lien.

4) **The COBC returns a *query response file within 14 days***.

5) **Each RRE must submit an A*uxiliary Report* to report additional claimants** associated with claims *previously submitted* on the claim input report *in the event*

- A beneficiary dies and a new entity takes their place
- or the TPOC (Total Payment Obligation to the Claimant) changes

The Amended CMS timeframes are:

Date	CMS Action Required
5/1/09 - 9/30/09	**Electronic Registration Period via Coordination of Benefits Secure Website (COB) for all RRE's-www.Section111.cms.hhs.gov**
7/1/2009	**Test & Production Query function will be available to each RRE who has completed registration and is in a testing status.**
1/1/10-3/31/10	**Claim Input File Testing period for every liability insurance, no-fault & workers compensation RRE.**
4/1/10-6/30/10	**First submissions of Production files based upon COBC assigned submission schedule to the RRE.**
7/1/2010	**Regular Production File Submission-Window extended to 1st qtr by 3-20-09 User Guide Change bulletin**

The challenge is capturing and retaining substantial data not previously required as well as navigating the gray areas where there currently is no rule. For more detailed information about the areas for potential issues, http://www.marccoalition.com is the link to the Medicare Advocacy Recovery Coalition (MARC).

Many entities are advertising agency service for the required MIR (Mandatory Insurer Reporting). We caution that few are comprehensively covering all of the steps outlined above, or providing data correction services or protection in the event a data submission fails exposing the RRE to potential fines for any delay in processing.

NARS is working with strategic partners on a comprehensive solution for little or no additional charge to our clients. We'll use secure file transfer protocol for electronic data submission and receipt of return feeds back to the claim system so that data corrections occur at the source data, not simply on the COBC site and the claim system remains a central repository of claims information to safeguard claims data.

For additional information concerning NARS' solution for CMS compliance, please contact, Karen O'Keefe-Payne at kokeefe@narisk.com or (800) 315-6090 extension 1212.