HOOPS 2008

MSP Update: New Programs, Added Burdens, Possible Expanded Opportunities – Focus on CMS Implementation of Mandatory Insurance Reporting

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BACKGROUND

- Mandatory Insurance Reporting requirements were enacted by Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA")
- CMS issued the "MMSEA Section 111 MSP Mandatory Reporting GHP User Guide" on October 16, 2008 (the "Guide"). It can be found at http://www.cms.hhs.gov/MandatoryInsRep/downloads/Section111GHPUserGuideV1510-15-08-Final.pdf.

PURPOSE OF MANDATORY REPORTING

- "The purpose of the Section 111 GHP reporting process is to enable CMS to correctly pay for the health insurance benefits of Medicare beneficiaries by determining primary versus secondary payer responsibility. Section 111 authorizes CMS and Section 111 GHP responsible reporting entities (RREs) to electronically exchange health insurance benefit entitlement information. The actual data exchange process will take place between the RREs and the CMS Coordination of Benefits Contractor (the COBC). The COBC will be managing the technical aspects of the Section 111 data exchange process for all Section 111 RREs." Guide at 13.

MANDATORY REPORTING OBLIGATION

- "On a quarterly basis, a responsible reporting entity must submit group health plan (GHP) entitlement information about employees and dependents to the COBC. In exchange, the COBC will provide the RRE with Medicare entitlement information for those individuals in a GHP that can be identified as Medicare beneficiaries. This mutual data exchange helps to assure that claims will be paid by the appropriate organization at first billing." Guide at 13.

OPTIONAL REPORTING

- "The Section 111 GHP reporting process includes an option to exchange prescription drug coverage information to coordinate benefits related to Medicare Part D. CMS is also allowing RREs, that are also participating in the Retiree Drug Subsidy (RDS) program or are reporting to RDS on behalf of a plan sponsor, to use the Section 111 GHP reporting process to submit subsidy enrollment (retiree) files to the RDS Center using the Section 111 GHP reporting process." Guide at 13.

PENALTY FOR NONCOMPLIANCE

- 42 U.S.C. §1395y(b)(7)(B)(i) - ENFORCEMENT:

- "An entity, a plan administrator, or a fiduciary . . . that fails to comply with the requirements [of this paragraph] shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual."

WHO IS RESPONSIBLE TO REPORT

- A [GHP] organization that must report under Section 111 is defined as “an entity serving as an insurer or third party administrator for a group health plan…and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary. These organizations are referred to as Section 111 GHP responsible reporting entities, or RREs. You must use the definitions given in Appendix H when determining whether or not you are a responsible reporting entity under this provision." Guide at 17.

WHO IS RESPONSIBLE TO REPORT

- "GROUP HEALTH PLAN (GHP) ARRANGEMENTS (42 U.S.C. 1395y(b)(7)) INSURER For purposes of the reporting requirements at 42 U.S.C.§1395y(b)(7), an insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. In instances where an insurer does not process GHP claims but has a third party administrator (TPA) that does, the TPA has the responsibility for the reporting requirements at 42 U.S.C. §1395y(b)(7).“ Guide at Appendix H.

WHO IS RESPONSIBLE TO REPORT

- Appendix H continues:
- "THIRD PARTY ADMINISTRATOR (TPA) For purposes of the reporting requirements at 42 U.S.C. §1395y(b)(7), a TPA is an entity that pays and/or adjudicates claims and may perform other administrative services on behalf of GHPs (as defined at 42 U.S.C. §1395y(b)(1)(A)(v)), the plan sponsor(s) or the plan insurer. A TPA may perform these services for, amongst other entities, self-insured employers, unions, associations, and insurers/underwriters of such GHPs. If a GHP is self-funded and self-administered for certain purposes but also has a TPA as defined in this paragraph, the TPA has the responsibility for the reporting requirements at 42 U.S.C. §1395y(b)(7)."

WHO IS RESPONSIBLE TO REPORT

- Appendix H concludes:
- "USE OF AGENTS FOR PURPOSES OF THE REPORTING REQUIREMENTS AT 42 U.S.C. §1395y(b)(7) Agents are NOT Responsible Reporting entities (RREs). However, for purposes of the reporting requirements at 42 U.S.C. §1395y(b)(7), agents may submit reports on behalf of: Insurers for GHPs TPAs for GHPs Employers with self-insured and self-administered GHPs.
- Accountability for submitting the reports in the manner and form stipulated by the Secretary and the accuracy of the submitted information continues to rest with each of the above-named RREs.
- CMS provides information on the method of identifying agents for reporting purposes in Section 6.1.1.2 of this User Guide."

PARTICULAR DATA ELEMENTS - SSNs

- SSNs of all subscribers must be submitted. There are no exceptions from, or extensions that apply to, this requirement.

- For spouses and other dependents whose coverage began before January 1, 2009, the Guide provides an extension for reporting SSNs for these spouses/dependents until the first submission in the first quarter of 2010.

- "The extension does not apply to spouse/family members whose initial GHP coverage effective dates are 1/1/09 or later." Guide at 36.

PARTICULAR DATA ELEMENTS - SSNs

- "The extension is provided to all Section 111 GHP responsible reporting entities during 10/1/2008 to 12/31/2009. It is intended to allow you time to obtain the SSN or HICN of spouses and family members. It does not apply to reporting subscriber information under any circumstances. You must have the SSN or HICN for subscribers at the start of Section 111 reporting and submit coverage information for Active Covered Individuals who are subscribers on your initial and all subsequent update MSP Input Files." Guide at 36.

PARTICULAR DATA ELEMENTS - SSNs

- Once these additional SSNs are reported, the report must be retroactive.

- "As of 1/1/2010, GHPs that were not reporting all required dependent coverage information must do so in their First Quarter (January – March) 2010 file. This report is to be retroactive and include all dependents with coverage effective dates prior to 1/1/09 which was still active on 1/1/09." Guide at 36.

CORRECTION OF SUBMITTED DATA

- The Guide envisions that SSN information may be incorrect, or even missing, and that the correct SSN will be supplied by the COBC. The following sentence appears several times in the Guide:

- "The following fields may contain updated information from the COBC based on Medicare's information and should be used to update your internal files:
  - HICN
  - Active Covered Individual/Beneficiary Name
  - Date of Birth
  - Gender
  - SSN." Guide at 37.

- It is unclear whether, and under what circumstances, the submission of incorrect or incomplete data will lead to a finding of noncompliance.

REGULATIONS NOT REQUIRED FOR IMPLEMENTATION

- Under 42 U.S.C. §1395y(b)(7)(D):

- "Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise."

EFFECT ON IRS/SSA/CMS DATA MATCH

- In the "Supporting Statement for the MSP Mandatory Insurer Requirements," issued on August 1, 2008, and found at https://www.cms.hhs.gov/MandatoryInsRep/Downloads/SupportingStatement082808.pdf, CMS said:

- "These collection activities were created to reduce both burden and redundancy. Successful implementation of mandatory insurer reporting will allow CMS to eliminate or curtail other Coordination of Benefit Contractor data collection processes such as the IRS/SSA/CMS Data Match." Supporting Statement at 6.

- This should reduce the burden on employers.

- Does CMS expect Mandatory Reporting to result in an increase in the MSP repayment demands?

QUESTIONS PRESENTED TO THE GOVERNMENT CONCERNING MANDATORY REPORTING

A. Implementation of the Mandatory Reporting Requirements

1. When does CMS expect to issue the MSP Mandatory Reporting User Guide for non-GHP responsible reporting entities?

2. 42 U.S.C. §1395y(b)(7)(D) states that "[n]otwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise." In enacting this clause, Congress departed from 42 U.S.C. §1395hh(a)(2), which states "[n]o rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation…."

   Historically, the notice and comment process has been an important way for CMS to get feedback from those affected by its policies. It also assured that those entities would receive official responses to their concerns. With that in mind, does CMS intend to use notice and comment rulemaking to implement the mandatory reporting requirements? If not, will CMS take any special actions to assure that affected entities have an opportunity to comment and receive official responses to their concerns?

QUESTIONS PRESENTED TO THE GOVERNMENT CONCERNING MANDATORY REPORTING

3. **The MSP Mandatory Reporting GHP User Guide ("the Guide") at 37 states as follows:**

   "The following fields may contain updated information from the COBC based on Medicare's information and should be used to update your internal files: HICN, Active Covered Individual/Beneficiary Name, Date of Birth, Gender, SSN."

   This is repeated several times in the Guide. It recognizes that, despite best efforts by the responsible reporting entity ("RRE"), the information that the RRE provides to the COBC, including SSNs and EINs, might not always be correct. Also, some requested information might not be available to the RRE. Under these circumstances, it appears that the COBC will confirm the accuracy of all submitted information provided and fix/add what it can. Is this correct? If so, this would be quite helpful because a RRE is not in a position to know whether all submitted information is correct and sometimes a submission might not be complete.

QUESTIONS PRESENTED TO THE GOVERNMENT CONCERNING MANDATORY REPORTING

4. In the "Supporting Statement for the MSP Mandatory Insurer Requirements," issued on August 1, 2008, CMS said:

   "These collection activities were created to reduce both burden and redundancy. Successful implementation of mandatory insurer reporting will allow CMS to eliminate or curtail other Coordination of Benefit Contractor data collection processes such as the IRS/SSA/CMS Data Match." Supporting Statement at 6.

   Does CMS expect Mandatory Reporting to result in an increase in the MSP overpayment demands?

5. Will CMS be issuing guidance concerning compliance and the circumstances under which civil monetary penalties ("CMPs") will be imposed? For example, would a RRE face a CMP where it does not possess in the normal course of business information required to be reported, such as SSNs/EINs, and, despite a good-faith effort, is unable to obtain them from the employer/plan?

QUESTIONS PRESENTED TO THE GOVERNMENT CONCERNING MANDATORY REPORTING

6. Section 111 of MMSEA requires liability, no-fault and workers' compensation plans to report claims by and settlements with Medicare beneficiaries to CMS. Will CMS forward that information to Medicare Advantage ("MA") plans when the beneficiary is enrolled in a MA plan?

7. Will MA and Part D plans be able to access the information provided to CMS under the Mandatory Reporting statute?

8. In light of the issues that have arisen surrounding the reporting requirement, is CMS considering delaying or staging implementation?

QUESTIONS PRESENTED TO THE GOVERNMENT CONCERNING MANDATORY REPORTING

9. ***The facts are as follows: an employer changes carriers and the replacement health coverage is to begin on 1/1/2009. Please confirm that the RRE/carrier has until the first quarter of 2010 to report SSNs for spouses and family members for those beginning coverage under the new carrier on 1/1/2009.***

QUESTIONS PRESENTED TO THE GOVERNMENT ON OTHER MSP ISSUES

B. Other MSP Issues

10. Has CMS changed its position regarding the rights/ responsibilities of MA and Part D plans under the MSP law? 42 U.S.C. §1395y(b)(2) gives the Secretary (and thus CMS) a number of powerful tools to enforce the MSP law. The Secretary, through 42 C.F.R. §422.108(f), has provided that, "The MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter." Despite this regulation, we are hearing that certain liability and no-fault carriers have been refusing to coordinate benefits with MA plans, allegedly based on advice from CMS. Are you aware of any change in CMS's position from what is in the regulation cited above?

QUESTIONS PRESENTED TO THE GOVERNMENT ON OTHER MSP ISSUES

11. Does CMS take the position that a MA or Part D plan may not bring an action for double damages under 42 U.S.C. §1395y(b)(3)(A) when a liability or no-fault plan is primary to the MA or Part D plan, but fails or refuses to pay primary (or make the appropriate reimbursement)?

QUESTIONS PRESENTED TO THE GOVERNMENT ON OTHER MSP ISSUES

12. What does 42 U.S.C. §1395w-22(a)(4) mean when it provides that MA plans may "charge or authorize the provider to charge" the primary plan? Courts have interpreted this to mean that if MA plans want to enforce their right to "charge" the primary plan, they must put "subrogation" language in the "insurance policy" issued to the MA beneficiary. *Care Choices HMO v. Engstrom*, 330 F.3d 786 (6th Cir., May 30, 2003). Has CMS considered clarifying what this statute means by regulation or in the MSP Manual, to correct these interpretations that limit the effectiveness of the MSP law?

CLOSING

Comments, Questions, and Answers