

Helping you navigate the Medicare, Medicaid and SCHIP Extension Act of 2007*

Part of our role as your insurance carrier is to keep you informed about new legislation impacting your business and to help you stay in compliance. As you may know, the reporting rules of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) took effect last year. The purpose of this document is to help you understand this legislation, how it affects your operations and what you can do to prepare, as well as what you can expect from Zurich.

This communication has been updated to reflect the November 9, 2010 ALERT from Medicare announcing the one year delay in reporting of Total Payment Obligations to the Claimant (TPOCs) with no On-Going Responsibility for Medicals (ORM), to first calendar quarter 2012.

First, some background

Medicare is a health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). Medicare originated with the enactment of the Social Security Act in 1965. At that time, Congress provided that Medicare would be the primary source of payment for a beneficiary's medical items and services, with the exception of workers' compensation insurance. In 1980, to reduce federal health care costs, Congress further amended the Act to make Medicare a secondary source of payment, rather than a primary one, so that workers' compensation insurers, and virtually all private insurers, are considered primary payers for a beneficiary's health care. This change is known as the Medicare Secondary Payer statute (MSP). The mandatory reporting requirements contained in MMSEA are, in turn, amendments to the Medicare Secondary Payer Statute. The federal agency in charge of administering and enforcing the Medicare Secondary Payer law, including the new reporting requirements, is the Centers for Medicare and Medicaid Services (CMS).

More about MMSEA

For various reasons, Medicare has not been able to identify primary payers consistently since the passage of the Medicare Secondary Payer Statute in 1980. Consequently, the original goal of the law – to reduce federal health costs – has not been met. In an effort to remedy this, Section 111 of the MMSEA was passed on December 29, 2007. It adds mandatory reporting requirements for liability insurance (including self-insurance), no-fault insurance and workers' compensation. These requirements impose an obligation on primary payers to identify claimants entitled to Medicare and report electronically claims that meet certain criteria to Medicare.

It's important to note that Section 111 does not change or eliminate any existing statutory provisions, regulations or processes, such as:

- CMS processes regarding identifying the private insurance primarily responsible for payment of a beneficiary's health care or Medicare's right to reimbursement for payments it has made
- Policies protecting Medicare's interests in settlements via Medicare set-asides
- CMS policies regarding recovery of conditional payments

The role of the Responsible Reporting Entity (RRE)

CMS refers to the party that is required to comply with Section 111 of MMSEA as the Responsible Reporting Entity (RRE). Electronic reporting is required for all RREs. The RRE is determined by who actually pays the loss rather than who ultimately funds the payment.

Generally, Zurich will be the RRE on all but self-insured accounts.

Type of insurance arrangement (regardless of claim handling entity).....RRE

| | |
|-------------------------------|---------|
| Guaranteed cost account | Zurich |
| Deductible account..... | Zurich |
| Self-insured account | Insured |

An RRE may contract with a vendor or third-party administrator to serve as its agent for reporting, but the RRE remains ultimately responsible for the reporting, and will be held liable for any penalties associated with non-compliance. Zurich has the ability to collect and transmit data to CMS as required by the MMSEA. Zurich has verified that approved TPAs have selected a reporting agent or are able to collect and transmit data to CMS themselves.

However, please be aware that if an insured pays a claim without informing its insurer, CMS will consider the insured responsible for Section 111 reporting.

Query Process

RREs are required to identify claimants who are Medicare eligible. CMS will advise the RRE of the claimant's Medicare status through a query process. To initiate the process, the RRE will electronically submit the following data on all claims involving an injury:

- Full legal name
- Social Security Number (SSN) or Health Insurance Claim Number (HICN)
- Date of birth
- Gender

If the claimant is eligible for Medicare benefits and certain thresholds are met, additional claim data must be submitted to CMS. Depending on the circumstances of the claim, the additional data may include information on:

- Ongoing Responsibility for Medicals (ORM) as of January 1, 2010
- The amount and date of a Total Payment Obligation to the Claimant (TPOC), (i.e., settlements, judgments or awards) not involving ORM, reached on or after October 1, 2011.
- Alleged product liability
- Legal representatives
- Dependent payees and dependent representatives

A penalty of \$1,000 per day may be imposed for each claimant that is not reported.

What Zurich is doing to prepare for MMSEA reporting and how we will help you

Zurich has been preparing for the implementation of Section 111 Reporting since 2008. We have assembled a team from various disciplines to review the new law, respond (along with other private carriers and state agencies) to CMS's pronouncements for implementation of the law, and develop solutions to meet the reporting requirements.

CMS continues to develop and revise the reporting requirements. Zurich will continue to monitor updates to the Act and offer you guidance on your reporting responsibilities, if applicable.

CMS events worth noting:

- CMS offers Computer Based Training on registration process
- Each RRE must register with CMS
- RREs or designated agents test system functionality and reporting with CMS January 1, 2010 to December 31, 2010
- First production input files for ORM with or without a TPOC to be submitted January 1, 2011.

- First production input files for TPOCs with no ORM involvement to be submitted January 1, 2012.

Some helpful resources:

CMS dedicated Section 111 website:

<http://www.cms.hhs.gov/MandatoryInsRep>

Coordination of Benefits Secure Website:

<https://www.section111.cms.hhs.gov/MRA/Login.action>

MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting user guide: <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuideV3022210.pdf>

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Zurich general mailbox for Section 111 related questions: USZ_RiskComplianceProjects@zurichna.com

Helpful Terms and Definitions

CMS (Centers for Medicare and Medicaid Services): An agency of the federal government that oversees the Medicare and Medicaid programs.

COBC (Coordination of Benefits Contractor): A contractor hired by CMS to identify primary payers and to coordinate the payment process to prevent a conditional payment of Medicare benefits.

COBSW (Coordination of Benefits Secure Website): CMS website used for registration and reporting.

Conditional Payment: A payment made by Medicare that is subject to reimbursement if another payer is determined to be responsible.

EDI (Electronic Data Interchange): A set of standards for computer-to-computer exchange of information.

HICN (Health Insurance Claim Number): The number assigned by the Social Security Administration to an individual identifying him or her as a Medicare beneficiary. This number is shown on the beneficiary's insurance card and is used in processing Medicare claims for that beneficiary.

MMSEA (Medicare, Medicaid and SCHIP Extension Act of 2007): Section 111 of this Act mandates additional reporting of claim data by primary payers on claimants who are eligible for Medicare benefits.

MSA (Medicare Set-Aside): A projection of future injury-related medical costs that are identified and funded as part of the settlement agreement. The set-aside protects Medicare's status as a secondary payer.

MSP (Medicare Secondary Payer): Refers to situations where another entity is required to pay for covered services before Medicare.

Medicaid: A program of medical aid funded by state and federal governments for those unable to afford medical services.

Medicare: A health insurance program for people age 65 and older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant).

No-fault Insurance: Includes both PIP (Personal Injury Protection) and Medical Payments coverages.

Query Process: Monthly, electronic submission of claim data to CMS to determine whether the claimant is Medicare eligible.

RRE (Responsible Reporting Entity): The party required to report claim data to CMS.

SCHIP (State Children's Health Insurance Program): A state program established in 1997 that is funded by the federal government to ensure that low-income children who are not eligible for Medicaid and are unable to pay for private insurance still have health care benefits.

TPA (Third Party Administrator): An organization that processes insurance claims.

ZSC (Zurich Services Corporation): A Third Party Administrator that provides claim services for Zurich customers.

Questions?
For more help please call our toll-free Help line at 1-866-732-5346 or speak to your local Zurich representative. For claims handled by a TPA – contact your TPA representative.

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