Part of our job as your insurance carrier is to help keep you informed on 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 on July 1, 2009. The purpose of this document is to help you understand this legislation, how it affects your operations and what you – if you are a Self-insured account should know, along with what you can expect from Zurich.

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, virtually all private insurers, would be 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 MSP statute. The federal agency in charge of administering and enforcing the MSP statute, 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.

Under Section 111, CMS has the authority to impose penalties of up to $1,000 per day for each claim that is not timely reported.

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

*Updated June 2015
The role of Responsible Reporting Entities (RREs)

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):

- Guaranteed cost account: Zurich
- Deductible account: Zurich
- Self-insured account: Insured

Zurich has the ability to collect and transmit data to CMS as required by Section 111 of the MMSEA. If the insured is RRE, the insured may contract with a vendor or third-party administrator (TPA) to serve as its agent for reporting, but the insured remains ultimately responsible for reporting and will be held liable for any penalties associated with non-compliance. Zurich can verify that the approved TPA has selected a reporting agent or is 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.

For Self-insured claims unbundled and handled by The Zurich Services Corporation (ZSC), ZSC could also act as your reporting agent. For Self-insured claims handled by a TPA, the TPA or their designee could act as your reporting agent. In either situation, the Self-insured account must register with CMS to obtain an RRE ID. The RRE ID must be provided to ZSC or the TPA.

CMS mandates that the RREs re-certify the information reflected in the CMS Profile on an annual basis in order for reporting to be accepted each quarter. If the information is not re-certified by the Authorized Representative (AR) of record, CMS will discontinue the use of the RRE ID and will not accept any reports until such time there is a re-certification.

What Zurich is doing to comply with the Section 111 MMSEA reporting and how we can help you

The following are a few highlights of Zurich’s very robust automated solution to manage the data in order to timely report mandatory data on behalf of Zurich as well as the ZSC Self-insured accounts.

- Monthly queries with Medicare to determine a claimants Medicare eligibility status
- Quarterly claim submissions to Medicare to report applicable claims
- Constant monitoring of real time reports to ensure data is properly updated for reporting

There is a full time dedicated Medicare Reporting Account Manager who is responsible for oversight of all aspects of monitoring. The Medicare Reporting Account Manager is available for any questions and/or assistance you may have regarding the Section 111 MMSEA reporting process, including but not limited to registering if you are a Self-insured account. The Medicare Reporting Account Manager can be contacted at 866-732-5346 or usz_sbolstermmsea@zurichna.com.

Zurich continues to monitor any updates to the reporting requirements and offer you guidance on your reporting responsibilities, if applicable.

Some helpful resources:

- Coordination of Benefits Secure Website: [https://www.section111.cms.hhs.gov/MRA/LoginWarning.action](https://www.section111.cms.hhs.gov/MRA/LoginWarning.action)
- Zurich general mailbox for Section 111 related questions: usz_sbolstermmsea@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.

BCRC (Benefits Coordination and Recovery Center): 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 (The 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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