



SPECIAL Alert

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In This Issue

In this eighth McGraw Wentworth Special Alert for 2008, we will discuss the recently released details of the Mandatory Medicare Secondary Payer Reporting requirements. In many cases, Medicare reserves a secondary payer status to other plans that may also be liable to pay for a Medicare beneficiary's medical expenses. Just like employers struggle with managing the coordination of benefits process, Medicare struggles as well.

This new mandatory reporting requirement primarily affects health plans and Third Party Administrators. These organizations will likely be providing CMS with your plan's eligibility data. However, it is important you confirm with your health plan that they will handle this reporting requirement. In addition, the health plan may not have all the information required by Medicare. They may need your assistance in tracking down the information so that a complete data file can be submitted to CMS.

We welcome your comments and suggestions regarding this issue of our Special Alert. For more information on this article, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

“Mandatory Medicare Secondary Payer Reporting”

Like most group health care plans, Medicare has secondary payer rules to determine which plan pays first and which pays second when more than one plan is involved in a claim. The Medicare, Medicaid and SCHIP Extension Act of 2007 requires group health plans and other entities to follow new reporting rules to make sure the Centers for Medicare and Medicaid Services (CMS) has enough information to determine the primary and secondary payer.

This Special Alert reviews the following issues arising from these new mandatory reporting requirements:

- Background: Determining Which Plan Pays First
- Current Process for Determining Status
- New Mandatory Electronic Reporting Requirements
- Providing the Social Security Number

The good news is that, for the most part, your health insurance carrier or your third party administrator will handle this mandatory reporting requirement. In order to ensure your vendor is providing the required information in the appropriate time

frame, you want to verify that your vendor is handling the reporting according to the rules.

Background: Determining Which Plan Pays First

Medicare rules dictate when Medicare is the secondary payer. These rules

have been modified over the years to ease the financial burden on Medicare whenever reasonable.

Medicare pays secondary to group health plans in the following situations:

following situations:

- For working employees age 65 or older covered by an employer-sponsored group health plan, if the employer has 20 or more employees.
- For Medicare beneficiaries who are 65 or older covered through a working spouse's group health plan if the employer has 20 or more employees.
- For Medicare beneficiaries with end stage renal disease (ESRD) covered by a group health plan. (Medicare is the secondary payer for a 30-month coordination period.)



- For disabled Medicare beneficiaries covered by their own or a family member's group health plan if the employer has 100 or more full- or part-time employees.

In addition, similar to group health plans, Medicare is the secondary payer when a liability carrier, such as no-fault auto insurance, workers' compensation, or general liability insurance, is paying medical expenses.

Current Process for Determining Status

CMS implements and oversees the Medicare secondary payer process. Although the secondary payer rules are fairly straightforward, CMS struggles with determining the primary payer. The current approach is not as effective as CMS would like.

CMS uses the following pre-payment data to determine in advance whether Medicare should be the primary payer:

- **Initial Enrollment Questionnaire:** CMS sends this questionnaire to Medicare beneficiaries to determine whether they are enrolled in an active group health plan. If so, Medicare would be the secondary payer.
- **Medicare Claim Payment Process:** Health care providers must include the patient's other insurance carrier information when they submit claims to Medicare so that CMS can coordinate benefits.
- **IRS/SSA/CMS Data Match Process:** CMS integrates information received from Medicare questionnaires with information from the IRS and the Social Security Administra-

tion. If the data suggests an employer's group health plan should be the primary payer, CMS will send a data match letter to the employer. This letter requests specifics about the coverage available and asks you to verify that the Medicare beneficiary is employed. The goal is to determine which plan should be the primary payer.

- **Voluntary Data Sharing Agreements:** Information is traded electronically between CMS and insurance carriers, employers and a limited number of workers' compensation carriers in an attempt to determine which plan should be the primary payer.
- **Medicare Beneficiaries:** CMS often receives critical information from the Medicare beneficiaries directly. They contact CMS contractors to report changes in their group health plan coverage.

CMS dedicates a significant amount of time to this process to ensure the Medicare beneficiary does not have other coverage that should be paying primary.

It is important to understand payment status up front. Medicare analyzes eligibility data after the claim has been paid to determine whether another party should have been the primary payer. CMS then uses specialty contractors to recover payments paid in error.

Because current methods for collecting data are somewhat hit and miss, it requires a significant amount of time and resources to determine the primary payer. The goal of the new mandatory reporting requirement is to trade data directly with health plans and workers' compensation carriers to track dual coverage situations more quickly and accurately.

New Mandatory Electronic Reporting Requirements

The new mandatory reporting requirement for group health plans is effective as of January 1, 2009. The new mandatory reporting requirement for liability carriers, such as workers' compensation carriers and no-fault auto carriers, is effective July 1, 2009.

CMS has hired contractors to help manage this mandatory reporting requirement (known as MIR or Mandatory Insured Reporting). The reporting entities will need to register on a secure website and the required data will be collected at least once every quarter. Once the registration is complete, CMS will begin working with the organization to set up the specific data reporting and response process. The secure web site is currently being developed.



Even though the industry standard is to retain records for five years, initially CMS *required* a ten-year retention period for Medicare secondary payer related information. However, in response to health plan concerns, the ten-year retention period is now *recommended* rather than required.

The good news is that this mandatory reporting requirement affects your insurance carriers and TPAs, and it does not necessarily affect you directly. CMS estimates a high percentage of group health plan insurers (roughly 70%) are already trading enrollment data with CMS through a voluntary data sharing agreement.

Your insurance carrier or TPA should let you know within the next month or two whether the required reports have been filed. If you do not hear from your carrier or TPA, you should call to confirm the mandatory reporting is being submitted.

Employers with self-funded, self-administered group health plans are responsible for reporting the information to CMS. CMS will display the required data format and explain the reporting process on its secure site.

Employers may not need to submit the mandatory reporting directly (if their insurer or TPA provides the information), but they may need to provide specific information. One data element that CMS requests is the social security number. Because CMS understands the sensitivity of this data, it explains why the mandatory reporting must include the social security number.

This issue is discussed thoroughly in the next section. Some employers are discovering they do not have social security numbers on file for some of their plan participants. These employers will have to track down that information.

Next year, employers will need to touch base with their workers' compensation carriers to make sure they are complying with the mandatory reporting rules.

Providing the Social Security Number

Providing an employee's or dependent's social security number is something that can send shivers down the spine of security-conscious professionals. CMS recognizes employers will be reluctant to provide such sensitive data. In fact,

it has received numerous questions regarding the need to provide the social security number.

CMS must receive the social security number of

plan participants because the Medicare program uses Health Insurance Claim Numbers (HICNs) to track beneficiaries in the Medicare system. The HICN is derived from an individual's social security number. Since CMS will be comparing your plan eligibility against Medicare's eligibility system, it needs to use the one number that is a unique identifier and common to both systems.

Employers still may be reluctant to provide this sensitive data. In the Medicare Mandatory Reporting guidance, CMS discusses the rules affecting employers and when the social

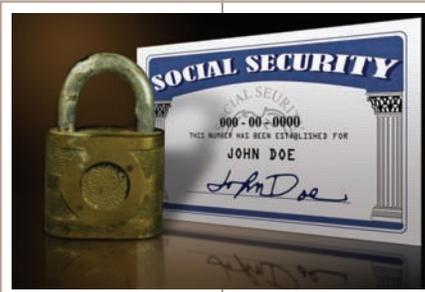
security number can be used. Although some state laws may govern how a social security number can be used, they do not pre-empt the Medicare secondary payer statute or the HIPAA Privacy Rules. Both these laws permit health plans to use the social security number for certain administrative functions. CMS points out that most social security laws merely prohibit employers from displaying the social security number on an ID card or mailing the social security number on an explanation of benefits letter.

HIPAA permits the trade of information with CMS to determine the primary payer. The new rules also detail the security measures CMS is taking to make sure that data transferred electronically remains secure.

Concluding Thoughts

The new mandatory Medicare secondary payer reporting requirements will apply to your group health plan and even your workers' compensation coverage. The good news is that the reporting requirement will apply to your vendors, such as your insurance carriers or third party administrators. However, your vendor may turn to you for the necessary information. At a minimum, you need to make sure your vendors have begun complying with CMS mandatory reporting rules.

If you have any questions, please contact your McGraw Wentworth Account Director. **MW**



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