LLOYD'S

MARKET BULLETIN

REF: Y4277

Title	New US Medicare reporting and registration requirements
Purpose	To advise the Market of the new legislation found under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007, which requires reporting of liability, medical expenses, workers compensation, personal injury and other claims information.
Type	Event
From	Cameron Murray, Senior Manager, International Regulatory Affairs General Counsel's Division
Date	12 May 2009
Deadlines	1 July 2009 – Registration 1 July 2009 to 31 December 2009 – Test reporting 1 January 2010 – Start of live reporting
Related links	http://www.cms.hhs.gov/MandatoryInsRep http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf

Who needs to read this Market Bulletin?

Managing Agents' Claims Managers and US Coverholders/TPAs dealing with the business lines listed in Appendix 2.

Summary of the New Law and Requirements for Lloyd's Syndicates

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) concerns new mandatory reporting requirements which will affect many syndicates writing US risks.

Readers of this document need to be mindful that the new law applies not just to health care insurance risks. Rather it impacts all syndicates writing any form of US liability insurance involving an injury to an individual person. It requires insurers to report on all such individuals with the aim of identifying whether a Medicare beneficiary is involved as a claimant. A Medicare beneficiary is a person who is eligible to receive Medicare benefits. The ultimate purpose of the measure is to ensure that the federal government makes full

recoveries from insurers for Medicare costs in instances where a Medicare beneficiary has been separately compensated for their injuries by a liability insurer.

Effective 1 July 2009, Medicare will require property & casualty insurers (including surplus lines providers) and certain stop loss and reinsurance placements which pay liability claims in respect of individuals to report the payment of the claim to the Centre for Medicare and Medicaid Services (CMS). Insurance providers responsible for reporting are to be called Responsible Reporting Entities (RREs). RREs are required to have completed a registration process with CMS by 1 July 2009. For further information on the applicability of this process to Lloyd's, please refer to 'Lloyd's Specific Issues' below and Appendix 1.

The new law requires that RREs submit two types of files. The first is a monthly query file, which the RRE uses to determine whether a particular claimant is a Medicare beneficiary. This file must contain identifying information for the claimant, such as social security number or Medicare Health Insurance Claim Number, surname, age, and gender. CMS will then notify the RRE whether each particular claimant is a Medicare beneficiary, such that reporting is required. The second file, submitted once per quarter, is the actual data report on claims paid to individuals identified as Medicare beneficiaries.

Scope and penalties of the measures

The new law does not exclude surplus lines insurers (which make up the majority of Lloyd's placements in the US) from registration and reporting requirements. We expect that Lloyd's syndicates writing US casualty business will need to provide reporting.

Reinsurers may also be required to report where they make direct payments to an injured claimant or representative of the injured claimant. Reinsurers and stop loss insurers who do not make direct payments to the injured claimant or representative of the injured claimant will be exempt from reporting. Also, if a reinsurer makes a payment to a self-insured entity which in turn pays the injured claimant or representative of the injured claimant directly, then they may not be required to report.

Failure to report the resolution of claims can incur fines and penalties, including fines for late notifications up to a maximum of $1,000 a day. Even if the RRE delegates the actual reporting to a TPA or other entity, the RRE remains liable for failure to report, late reporting, or report of inaccurate information.

Next Steps

The first deadline is that for registration and, as explained above, Lloyd's will assist in the registration process and, if possible, register the Market centrally. Lloyd's will shortly issue a further market bulletin explaining the registration process in further detail than that contained in Appendix 1 and requesting information to complete this.

Overall these reporting requirements present some significant challenges and therefore Lloyd's feels it would be best to convene a working group to secure market input and to look at their implementation. Lloyd's does not believe that it or XCS currently receives sufficient detail about the settlement of individual claims to satisfy the requirements. The fields of information required include Social Security Numbers and Medical Treatment Codes. Possible solutions include managing agents reporting directly, delegating to coverholders and TPAs in the US or, alternatively, a centralised solution, which will require the market to agree to a single, collective process. In addition, an appropriate approach will need to be agreed for subscription business.

Lloyd's Specific Issues

The Center for Medicare and Medicaid (CMS) has dealt with health plans in the past. It is striving to establish practices which work for liability insurers and syndicates. In doing so, it has encountered a number of issues and has been late in making public the instructions as to how the regulations will apply to liability insurers.

Lloyd's is making representations to CMS on a number of points. It is approaching CMS on the question of whether Lloyd's may register overall as an RRE or whether each syndicate must do so. It is likely that Lloyd's will facilitate the provisional registration of each syndicate, while exploring the possibility with the CMS for the registration deadline to be deferred.

Lloyd's is also in discussions with CMS about the use of federal tax ID numbers for validation purposes. Also, Lloyd's will need to approach the CMS to ensure a solution can be reached to the reporting of subscription risks, possibly enabling co-ordination of reporting via the leader. As currently drafted, the regulations would require each syndicate to report each claim separately. This will be clarified in subsequent consultation with the Market and in Market Bulletins.

While Lloyd's expects that certain items in the various guidance documents may change as CMS becomes more familiar with the London market, Lloyd's does not expect the reporting requirement to be waived for liability insurers.

Further Contacts

As mentioned in 'Next Steps' above, Lloyd's is forming a working group to study this issue with the market. If you would like to be involved in further consultations on this, please contact:

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FAQs

What is Medicare?
Medicare is the US Federal healthcare programme for persons over 65. Certain other eligible persons regardless of age, having a long term illness (such as permanent kidney failure) or other disability may also be covered.

What is 'Medicare as a Secondary Payer'?
Medicare as a Secondary Payer refers to situations where another entity is required to pay for covered services before Medicare does, and must do so without regard to a patient's Medicare entitlement. Under US law, liability insurers are such entities that are required to pay for covered services before Medicare.

What is the Centre for Medicare and Medicaid Services (CMS)?
The CMS is a Federal agency within the Department of Health and Human Services responsible for the administration of the Federal Medicare Health Insurance Programme.

For more information on this please see the following links:
http://www.cms.hhs.gov/MandatoryInsRep
http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf
Please note that CMS is continually updating available information, and as a result, information contained in this Bulletin is subject to change or update. More information will be provided in future bulletins.

Appendix 1: The Registration Process for RREs

Lloyd's is still exploring with CMS the question of whether Lloyd's may register overall as an RRE or whether each syndicate must do so. It is likely that Lloyd's will facilitate the provisional registration of each syndicate, while exploring the possibility with the CMS for the registration deadline to be deferred. A further Market Bulletin will be issued dealing with the question of registration once clarification is received from CMS.

What is a Responsible Reporting Entity (RRE)?

42 U.S.C. 1395y(b)(8) defines the Responsible Reporting Entity to be the "applicable plan", which is broadly defined to include the fiduciary or administrator for a law, plan or arrangement that writes liability (including self-insurance), no-fault, or workers compensation cover.

The CMS classifies many insurance and reinsurance companies as Responsible Reporting Entities (RREs). As mentioned above, RREs must report claims if they pay a Medicare beneficiary, or a representative of the Medicare beneficiary directly. However, if reinsurers make payment to a self-insured entity which in turn pays the injured claimant or representative of the injured claimant directly, then they may not be deemed an RRE and do not need to report.

What is required for registration?

For registration purposes, each RRE must select an individual to serve as the "Authorized Representative". This should be an executive or someone in a position of authority who is capable of responding on behalf of the syndicate. It is recommended that this individual be the head of claims or in a similar position for the syndicate. The same individual may serve as the Authorized Representative for more than one reporting syndicate. The Authorized Representative is a person who is not involved in the day-to-day reporting, but rather serves as CMS's main contact at the RRE.

Additionally, each RRE must select an individual to serve as the "Account Manager". This person will be more involved in oversight of reporting. If the syndicate chooses to delegate reporting responsibility to a Third Party Administrator (TPA), the Account Manager may be the contact person at the TPA. The Account Manager will then delegate the data entry to other individuals. If multiple Agents such as TPAs are used to file reports, the RRE (syndicate) must undertake the registration process and obtain an RRD ID for each of its agents. More information regarding registration will be forthcoming in a subsequent Market Bulletin.

Data reported for purposes of MMSEA Section 111 by RREs will be submitted electronically to CMS' Coordination of Benefits Contractor (COBC). RREs will register on-line through a secure web site. Once an RRE's registration application is submitted, the COBC will begin working with the RRE to set up the data reporting and response. There will be a testing

period, from 1 July 2009 to 31 December 2009, during which RREs can submit test files using real data to ensure that they will be ready to report data when the actual reporting begins. Each RRE will be assigned a one-week time period during the first quarter of 2010, during which the RRE's first official data report must be submitted.

Appendix 2: Ongoing Reporting Process and Requirements

What are the obligations under MMSEA Section 111?

MMSEA Section 111 requires all property & casualty insurers that pay a liability claim that includes medical expenses or releases the insurer from liability for medical expenses to any Medicare beneficiary (or their representative) must report the claim to the Centre for Medicare and Medicaid Services (CMS).

For example, MMSEA Section 111 would apply to all applicable plans that pay:

- homeowners' liability insurance
- automobile liability insurance (including uninsured / underinsured motorist liability insurance)
- product liability insurance
- liability insurance (including self-insurance)
- no-fault insurance
- workers' compensation plans
- malpractice liability insurance
- medical payments coverage /personal injury protection / medical expense coverage

MMSEA Section 111 can also apply to umbrella and excess liability coverages.

The reporting requirements also apply to captive insurers, risk retention groups and risk purchasing groups providing liability insurance.

CMS will require any entity paying claims on the above lines, including reinsurance, self-insurer stop loss insurance, excess insurance, umbrella insurance, state guaranty funds, and patient compensation funds to register as Responsible Reporting Entities (RREs) if they make payments directly to a Medicare beneficiary (see Appendix 1 above). In order to determine if a claimant is a Medicare beneficiary, the RRE must submit data regarding every claimant's identity to CMS. CMS will then return a file to the RRE, indicating which claimants are Medicare beneficiaries and thus trigger the reporting requirements.

MMSEA Section 111 also requires Group Health Plan insurers to:

- determine if a claimant (including an individual whose claim is unresolved) is entitled to benefits under Medicare programme on any basis; and
- if the claimant is determined to be so entitled to Medicare, the GHP must then submit the identity of the claimant and any additional relevant information requested on a quarterly basis to the Centre for Medicare and Medicaid Services. The entity that is making the claim payments is responsible for reporting the required information regardless of whether it is reimbursed by another entity for those payments.

What Triggers Reporting?

RREs are required to report once a settlement, judgment, award or other payment has been made to a Medicare beneficiary or his or her representative. The RRE is required to submit data on all claims that have been paid since the RRE's last reporting date. However, if the claim is paid within 45 days of the RRE's reporting date, the RRE may wait until the following quarter to report the data. The initial report during the first quarter of 2010 must have information on claims paid 1 July 2009 and later.

As previously mentioned, general registration requirements need to be complied with and are in addition to the separate reporting requirements. General registration obligations must be completed in advance so as to permit a RRE to report future claims.

Therefore, this June, syndicates must register online with CMS as responsible reporting entities. Insurers must also enrol any agents or third party administrators that will submit data files on their behalf. Insurers who use the services of agents still retain all liability for reporting obligations.

Failure to report the resolution of claims can incur fines and penalties including fines for late notifications which can be as much as $1,000 a day. Even if the RRE delegates the actual reporting to a TPA or other entity, the RRE remains liable for failure to report, late reporting, or report of inaccurate information.

Although actual reporting does not go live until the first quarter of 2010, the first deadlines for insurers with reporting obligations are rapidly approaching. By July, insurers (or their agents) must have installed the software system which will be provided by the CMS. They will then be required to begin sending test data.

After a number of test transmissions have been sent, the CMS will allocate every insurer a one-week period during the first quarter of 2010, by which it must begin actual reporting on a quarterly basis. Reporting will then continue indefinitely.

The CMS has now published a registration and reporting guideline for all RREs to follow. Syndicates are advised to make sure they are familiar and compliant with these new reporting requirements in advance of July 2009. The document is available here: http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf

How does the reporting cycle work?

The new law requires that RREs submit two types of filings. The first is a monthly query filing to CMS which the RRE uses to determine whether a particular claimant is a Medicare beneficiary. This file must contain identifying information for the claimant, such as social security number or Medicare Health Insurance Claim Number, surname, age, and gender. CMS will then notify the RRE whether each particular claimant is a Medicare beneficiary, such that reporting is required.

The second filing, made once per quarter, is the actual data report on claims paid to individuals identified as Medicare beneficiaries. Upon registration, RREs will be assigned to one of 12 groups which will be required to report in sequence in successive weeks during the quarter. This way, the flow of information to CMS will be staggered. However, it also means that Lloyd's is unable to alert the market to specific reporting deadlines until syndicates are registered.

What data will need to be reported?

MMSE Section 111 requires that insurers report data that has been determined to be necessary to CMS for coordination of benefits purposes. The type of the information that must be reported includes, among other things:

- Identifying information for claimants, including social security number or Medicare Health Insurance Claim Number, age, gender, and name.
- The amount of the payment to the claimant, and when the payment was made.
- Whether the RRE has an ongoing responsibility for medicals. Note that this requirement triggers additional monitoring obligation, in case a claimant is not a Medicare beneficiary at the time that the responsibility is initiated, but becomes a Medicare beneficiary before the termination of the responsibility.
- Information which identifies the alleged cause of injury or illness, and diagnostic codes to identify the type of injury or illness.

For more information on this please see the following link: http://www.cms.hhs.gov/MandatoryInsRep. Please note that CMS is continually updating available information in the run-up to implementation. As a result, information contained in this Bulletin is subject to change or update. More information will be provided in future bulletins.