SUPPORTING STATEMENT FOR THE
MEDICARE SECONDARY PAYER (MSP)
MANDATORY INSURER REPORTING REQUIREMENTS OF SECTION 111
OF THE MEDICARE MEDICAID, AND SCHIP EXTENSION ACT OF 2007
(MMSEA) (P.L. 110-173)
See 42 U.S.C. 1395(b)(7) and (8).

A. Background

The Centers for Medicare & Medicaid Services (CMS) collects various data elements from the applicable reporting entities (see supporting documents) for purposes of carrying out the mandatory MSP reporting requirements of Section 111 of the MMSEA. This information is used to ensure that Medicare makes payment in the proper order and/or takes necessary recovery actions.

"MSP" refers to those situations where Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary. Under the law, Medicare is a secondary payer to Group Health Plans (GHPs) for certain beneficiaries, those:

- who are age 65 or older and working with coverage under an employer-sponsored and/or contributed to GHP, for an employer with 20 or more employees (or if it is a multi-employer plan where at least one employer has 20 or more full or part-time employees);
- who are age 65 or older and with coverage under a working spouse's employer-sponsored and/or contributed to GHP, for an employer with 20 or more employees (the working spouse can be any age)(or if it is a multi-employer plan where at least one employer has 20 or more full or part-time employees);
- who have End Stage Renal Disease (ESRD) and are covered by a GHP on any basis (Medicare is secondary for a 30 month coordination period.); or
- who are disabled and have coverage under their own or a family member's GHP for an employer with 100 or more full or part-time (or if it is a multi-employer where at least one employer has 100 or more full or part-time employees.)

Medicare is also a secondary payer to liability insurance (including self-insurance), no-fault insurance and workers' compensation.

1. Purpose

The purpose of this submission is to renew the 2009 Supporting Statement which set forth what information will be collected pursuant to Section 111 and the process for such collection. The information is collected from applicable reporting entities for the purpose of coordination of benefits. Section 111 mandates the reporting of information in the form and manner specified by the Secretary, DHHS. Data the Secretary collects

is necessary for both pre-payment and post-payment coordination of benefit purposes, including necessary recovery actions.

Section 111 establishes separate mandatory reporting requirements for GHP arrangements as well as for liability insurance (including self-insurance), no-fault insurance, and workers' compensation. (For purposes of this document, these may collectively be referred to as "non-GHP.") The effective date for the implementation of reporting of group health plan information was January 1, 2009 and for non-group health plan information it was July 1, 2009. Non-group health plan information collection was implemented in phases. With the passage of Section 111, CMS has the authority to mandate the reporting of insurer MSP information. ***(See Attachment A – Definitions and Reporting Responsibilities)***

2. The Federal Role

The CMS is responsible for oversight and implementation of the MSP provisions as part of its overall authority for the Medicare program. The CMS accomplishes this through a combination of direct CMS action and work by CMS' contractors. The CMS efforts include policy and operational guidelines, including regulations (as necessary), as well as oversight over contractor MSP responsibilities.

As a result of litigation in the mid-1990's, CMS received mandatory reporting from certain GHP insurers for a number of years. Subsequent to this litigation related mandatory reporting, CMS instituted a Voluntary Data Sharing Agreement (VDSA) effort which expanded the scope of the GHP participants and added some non-GHP participants. This VDSA process complemented the IRS/SSA/CMS Data Match reporting by employers, but clearly did not include the universe of primary payers and had few non-GHP participants.

Both GHP and non-GHP entities have had and continue to have the responsibility for determining when they are primary to Medicare and to pay appropriately, even without the mandatory Section 111 process. In order to make this determination, they should already and always be collecting most of the information CMS will require in connection with Section 111 of the MMSEA.

3. Current MSP Information Gathering Processes

MSP is generally divided into "pre-payment" and "post-payment" activities. Pre-payment activities are generally designed to stop mistaken primary payments in situations where Medicare should be secondary. Post-payment activities are designed to recover mistaken payments or conditional payments made by Medicare where there is a contested liability insurance (including self-insurance), no-fault insurance, or workers' compensation which has resulted in a settlement, judgment, award, or other payment. Most MSP activities are performed by CMS specialty contractors.

Pre-payment activities include:

Initial Enrollment Questionnaire (IEQ) Process: The IEQ is a questionnaire to beneficiaries which permits CMS to determine if there is an MSP occurrence at the time the beneficiary becomes entitled to Medicare.

Medicare's Claims Payment Process: Providers, physician, and other suppliers submitting claims to Medicare include coordination of benefit information on the submitted claim.

IRS/SSA/CMS Data Match Process: Data matched by these three agencies results in questionnaires to employers regarding certain employees' GHP coverage. The information received from employers is used to update CMS records.

VDSAs: Information obtained through this voluntary process from insurers, employers, and a limited number of workers' compensation entities is used to update CMS records.

Self-Identification of an MSP Occurrence: Beneficiaries/beneficiaries representatives contact the appropriate CMS contractor to report changes in their GHP coverage or self-identify a non-GHP occurrence.

Section 111 Mandatory Reporting- insurers must report situations where Medicare does not have primary payment responsibility, including both Group Health Plans and Non-Group Health Plans.

Post-payment activities include:

Debt Recovery: A CMS specialty contractor is responsible for pursuing recoveries where CMS records identify mistaken payments as well recovery claims due to conditional payments once a there is a settlement, judgment, ward or other payment.

B. Justification

1. Need and Legal Basis

The statutory basis for this information collection is Section 111 of the MMSEA which amended the MSP provisions found at 42 U.S.C. 1395y(b). See 42 U.S.C.1395y(b)(7)&(8) which add separate mandatory reporting requirements for GHP arrangements and for non-GHP (liability insurance including self-insurance, no-fault insurance and workers' compensation). The following laws/regulations describe existing MSP information collection:

LAW/REGULATION	EFFECT
42 U.S.C. 1395y(b)(7)	Mandatory reporting requirements for GHP
42 U.S.C. 1395y(b)(8)	Mandatory reporting requirements for non-GHP (liability insurance including self-insurance, no-fault insurance and workers' compensation)
42 U.S.C. 1395y(b)(5)(D)	Prior to an individual's applying for benefits under Part A or enrolling in Part B, the Secretary is to mail a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of coverage under such a plan
42 U.S.C. 1395w-102(b)(4)(D)(ii)	Allows Part D plans and plan sponsors to ask beneficiaries about what other coverage they may have, and states that material misrepresentation of such coverage by the beneficiary is grounds for termination from Part D
42 CFR 411.25	If a third party payer learns that CMS has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must provide notice to that effect
42 CFR 489.20(f) and (g)	Provider (defined in 489.2(b)) agrees to maintain a system that identifies payers primary to Medicare during the admissions process and to bill other payers primary to Medicare except when the primary payer is a liability insurer

The following laws contain MSP amendments or implications:

LAW	EFFECT
Original Title XVIII of the Social Security Act	Medicare is secondary to Workers' Compensation (including Black Lung).
§ 953 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1980	Medicare is secondary to Automobile, Liability, and No-Fault coverage

COBRA 1981 § 2146 as amended	Medicare is secondary for beneficiaries with ESRD in their first 30 months of eligibility.
§ 116 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982	Medicare is secondary for working beneficiaries age 65 to 69 and their spouses age 65 to 69 who are covered by an Employer GHP
§ 2301 of the Deficit Reduction Act (DEFRA) of 1984	Medicare is secondary for beneficiaries age 65 to 69 regardless of working spouse's age
COBRA 1985 § 9201	Eliminates upper age limit of 69 for "working aged" MSP
COBRA 1986 § 9319	Medicare is secondary for disabled beneficiaries classified as "active individual" and covered by a Large GHP (LGHP)
COBRA 1987	Clarifies that COBRA 1986 applies to governmental entities
COBRA 1989	MSP uniformity provisions and IRS/SSA/CMS Data Match added
COBRA 1993	Changes basis of MSP for disabled beneficiaries from "active individual" to "current employment status"
MMA § 1860D-2(a)(4)	Applies MSP laws to the new Medicare Part D in the same manner as it applies to Part C (Medicare Advantage, formerly Medicare+ Choice)
§ 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (PL 110-173)	Mandatory reporting requirements for GHP arrangements and for Non-GHP (liability insurance including self-insurance, no-fault insurance and workers' compensation).

These laws create a continuing need for information collection so that Medicare makes payment in the proper order and takes recovery actions as appropriate.

2. Information Users

CMS contractors assist in the administration of the reporting requirements of Section 111. This effort is frequently referred to as "Mandatory Insurer Reporting" (MIR). The applicable reporting entities register on-line by logging on to a secure website as a first step in complying with MIR. Once the applicable reporting entity submits its

application via the secure website, CMS begins working with the entity to set up the data reporting and response process.

CMS and its contractors use this information to ensure that payment is made in the proper order and to pursue recovery activities.

3. Improved Information Technology (IT)

CMS continues to increase its use of IT applications to collect as much information electronically as it can using processes such as Section 111 and VDSAs. Many other routine development activities are paper based, manual data collection processes. CMS has been rapidly moving to convert from paper into electronic collection systems. Mandatory insurer reporting is a 100 percent electronic reporting process, which leads to a reduced need for other paper based routine development activities.

4. Duplication of Similar Information

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

5. Small Business

Even though relatively few small businesses will be impacted by this legislation, CMS has made efforts to minimize the burden that this collection of information has on all submitting entities, including small businesses. Towards this end, CMS has made the application process completely electronic. The completion and submission of the MIR application takes place on-line via a CMS secure website. In addition, there is an on-line Direct Data Entry (DDE) option available to small NGHP reporters to simplify their reporting process. Development of a DDE option for small GHP reporters will be evaluated in the future.

6. Collection Frequency

Collection is on a no more than a quarterly basis. GHP data is submitted by the applicable reporting entity on an ongoing quarterly basis. Non-GHP data is submitted on an ongoing basis for no-fault insurance and workers' compensation for non-contested claims, when there is something to report, and on a one time basis for contested cases where there is a single settlement, judgment, award, or other payment.

Collecting information on a less frequent basis than is provided for in this submission will continue to create risk to the integrity of the Medicare trust funds. CMS has

reduced duplicate or redundant MSP data collection by placing the responsibility of all MSP collections with one umbrella contractor, effective January 8, 2001.

7. Special Circumstances

Five years is generally recognized as the standard for record retention in the industry. However, CMS recommends a record retention period of ten years for MSP related information. The CMS changed from "required ten years" to "recommend ten years" in the MSP PRA Information Collection submission in July 2005. Absence of related information does not constitute a valid defense against an MSP recovery action.

Note: Administrative offset is permitted for 10 years. Additionally, False Claim Act actions can be brought for 10 years.

8. Federal Register Notice/Outside Consultation

The customary 60-day notice will be published on or about May 17, 2013.

The CMS has established a separate MIR webpage for Section 111 of the MMSEA and its continued implementation. Informational materials as well as instructions can be downloaded from this webpage. The materials include both draft and final documents, including information on how interested parties may comment on the documents and/or CMS' implementation of Section 111. The webpage can be found at: www.cms.gov/MandatoryInsRep/.

The CMS held listening sessions with affected groups and continues to hold open door forum calls. The CMS has an email link for interested parties to sign up to receive email alerts whenever the webpage is updated. This link is available on the MIR webpage cited above.

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents.

10. Confidentiality

Laws, regulations and guidance associated with the Health Insurance Portability Act (HIPAA) and the Privacy Act apply to any information collected by CMS for purposes of this program.

11. Sensitive Questions

There are no questions of a sensitive nature associated with these requirements.

12. Burden Estimate (hours and wages)

For both GHP and non-GHP situations, there has been a longstanding obligation to determine the correct order of payment and pay correctly. For example, see 42 C.F.R. 411.25 and associated Federal Register General Notice published January 31, 1994 (Vol. 59, No. 20, Monday, January 31, 1994, p. 4285). Additionally, many of the data elements not required for coordination of benefit purposes are required for internal business purposes. Consequently, CMS does not believe that the collection of the required data elements causes an undue burden although for newly registering reporters there may be an initial effort involved in centralizing such information for reporting purposes.

Although CMS already routinely collects HICNs/SSNs from many reporting entities on a voluntary basis, for purposes of this Burden Estimate we are calculating the burden on the assumption that, in order to comply with the MIR requirements, the responsible reporting entities will have to solicit HICNs/SSNs from most of their covered Medicare beneficiaries (newly covered, new Medicare beneficiaries, or non-group health plans). The following calculations represent CMS's best estimate of its share of the paperwork burden regarding this collection. Estimates have been revised from Supporting Statement of 2009 to reflect actual historical numbers, acknowledge prior HICN/SSN collection for current beneficiaries and better estimates derived from experience. (***See Attachment B – The Need for Health Insurance Claim Numbers and/or Social Security Numbers***)

GHP

Close to all of GHP arrangements for which there is MSP involvement are already reporting to CMS. We estimate that data for some ninety-eight percent (98%) of all GHP covered lives is now received each calendar quarter by the CMS. For these currently reporting entities, there will be a decreased burden needed to submit the required GHP data.

There will also be a greatly reduced burden for system setup since reporting entities' systems are already set up and will only require maintenance. We do expect a very small number of new GHPs to register each year and incur the burden of a new system setup.

New GHP applicable reporting entities will need to follow the existing and well established process leading to routine GHP MSP coordination of benefits as managed by the CMS Coordination of Benefit Contractor. Once a new GHP applicable reporting entity has registered with CMS, the common and readily available GHP data elements required (S***ee GHP USER GUIDE***) will be electronically submitted to CMS. Current Section 111 partners report that, once established, the management of coordination of benefit data through this process is a routine business procedure. Establishing the data

exchange process initially takes, on average, the work of three employees five hours a day for 25 days, or a total of an average of 375 man hours. For reporters with established systems we estimated maintenance to be about 20 hours a year. In addition, based on experience with the current processes for each entity we estimate an average of 2 hours to perform the administrative work, including recertifying annually. CMS estimates that approximately 1550 private and 100 State, local or tribal Government GHP entities are required to/are reporting information to CMS under MIR.

CMS collected approximately 6,655,200 "new" GHP MSP records where the beneficiary has health insurance coverage through their employer or the beneficiary was covered through their working spouse's health insurance coverage. This number includes annual renewals and "add/deletes". CMS estimates the annual number of "new" records where HICN/SSN collection is necessary to be unchanged from the 3,515,000 predicted in the 2009 Supporting Statement.

CMS estimates that it currently has GHP data on approximately 98 percent of current beneficiaries where another GHP arrangement is primary to Medicare. CMS also estimates that approximately 97% of GHPs are currently reporting. System set-up costs have been adjusted to reflect that the majority of "set-up" cost will be for maintenance, with very few GHPs required to set-up a new reporting system.

HICN/SSN Collection: 5 minutes x 3.7 million responses = 308,322 hours x $18/hour = $5,549,796
System Set-Up Costs: 30.65 hours x 1,650 responses = 50,572.50 hours x $36/hour = $1,820,610
Ongoing Administrative Burden = 2 hours/response x 1,650 responses = 3,300 hours x $18/hour=$59,400

Total GHP burden = 308,322 hours + 50,572.5 hours + 3,300 hours = 362,194.50 hours

This represents a decrease in both hours and costs from the 2009 Supporting Statement.

Non-GHPs

For most non-GHPs, gathering the data required for MIR is not a considerable burden. Because the applicable reporting entities have had a long-standing obligation to coordinate claims payment with the Medicare program and to pay claims for health care in the proper order, and based on the experience of the last 3 years, CMS must assume the Non-GHP entities currently collect the data required for reporting. In addition, the effect of the initial burden of MIR has shown to not be very laborious since Non-GHP entities payers have obtained the data in order to properly conduct their own business operations.

Most Non-GHP entities are now reporting to CMS on a regular basis and have adopted the reporting methodology developed for them by CMS. Once a Non-GHP applicable reporting entity has registered with CMS, the common and readily available non-GHP data elements (***see Non-GHP User Guide Chapter V***) are electronically submitted to CMS. Reporting for contested claims which have been resolved through a single settlement, judgment, award, or other payment is a one-time occurrence. For Non-GHP entities reporting ongoing payment information requiring coordination of benefit follow-up, ongoing management of coordination of benefit data through the established reporting process should be a routine business procedure. Current NGHP RREs report that, once established, the management of coordination of benefit data through this process is a routine business procedure. For those required reporting entities that still will have to establish routine reporting to CMS, establishing the data exchange process initially takes, on average, the work of three employees five hours a day for 25 days, or a total of an average of 375 man hours. CMS estimates that more than approximately 99% of NGHPs that would use file exchange are already reporting. If an RRE is already reporting via file exchange, the set-up burden is minimal (for maintenance). If choosing to use the Direct Data entry, there is minimal set-up time required. In addition, based on experience, for each entity we estimate an average of 2 hours administrative work to assemble the applications, recertify annually and any other administrative tasks. CMS estimates that approximately 400 large non-GHP entities are required to report information to CMS under MIR on an ongoing basis. CMS estimates that there will be approximately 2.9 million non-GHP claims made annually by Medicare beneficiaries that may or may not be settled. The current number is slightly lower, but as more thresholds phase out reporting increases. For purposes of this estimate, CMS assumes that all will be settled and reported to CMS under the MIR program. CMS assumes 90 percent of the records are/will be reported by the approximately 400 non-GHP entities that are required to report information to CMS on an ongoing basis and some other smaller reporters, and that 10 percent are/will report on an as needed basis through direct data entry via the internet. Based on the Coordination of Benefit Contractor, reporting time for direct data entry is approximately 18 minutes per record.

HICN/SSN Collection: 5 minutes x 2,925,802= 243,817 hours x $18/hour = $4,388,706
System:
Private - 12.375 hours x 19,920=246,510 hours x $36/hour = $8,874,360
State Local and Tribal – 5.425 hours x 100= 542.5 hours x $36/hour = $19,530
Federal – 9.425 hours x 1,077= 10,150.725 hours x $36/hour = $365,426.10
Total – 257,203.225 hours x $36 = 9,259,316.10

Combined Administrative: (2 hours x 19,920+100+1,077) = 42,194 hours x $18/hour = $759,492

Combined System and Administrative Burden Hours: 299,397.225

Total non-GHP burden = 243,817 hours + 299,397.225 = 543,214.225 hours

This represents a decrease in hours from the 2009 Supporting Statement. Costs are higher due to updated cost estimates.

The overall burden for completing MIR is primarily dependent upon the number of individuals for whom an insurer must report information. Other influencing factors may be:

- the accessibility and format of personnel and health plan(s) records;
- the number of GHPs offered by an organization;
- the frequency of changes between plans or in coverage elections; and
- the format the insurer uses in responding to the collection activity.

The majority of the burden for completing MIR is system/reporting related and includes the time taken to: 1) review the instructions, 2) search for and compile the needed data, and 3) complete the record/report.

Burden can also be attributed to insurer familiarity with the reporting process, data required on fewer covered individuals and for more current periods of time, enhancements to the reporting system, and clarifications made to the instructional materials that address insurer questions or concerns.

13. Capital Costs

There are no capital costs. We have assumed that all required reporting entities will own at least one computer and have access to the internet.

14. Cost to Federal Government

CMS estimates that annual ongoing maintenance and support costs for this activity will continue to be approximately $8 million per year.

15. Program Changes/Changes in Burden

There is no additional information being requested under MIR that is not currently being requested by CMS, and in many instances voluntarily provided, that allows CMS, and other payers, to fulfill its obligations under the MSP statute. The CMS has established a separate MIR webpage for Section 111 of the MMSEA and its implementation. Informational materials as well as instructions can be downloaded from this webpage. The webpage can be found at: www.cms.hhs.gov/MandatoryInsRep/. CMS has published a detailed GHP User Guide and a detailed Non-GHP User Guide for liability insurance (including self-

insurance), no-fault insurance and workers' compensation, as downloadable PDF files that provide additional detail regarding the mandatory MSP reporting requirements of Section 111 of the MMSEA.

16. Publication and Tabulation

There are no plans to publish or tabulate the information collected for statistical use.

17. Expiration Date

We request that this requirement be excepted. Due to the ongoing nature of this collection, we do not believe a reference to an expiration date is in the best interest of this collection. The omission of the expiration date will obviate the necessity to reprogram our systems each time OMB extends approval for MSP data collection.

18. Certification Statement

There are no exceptions to the certification statement.

D. Statistical Methods

This collection of information does not employ statistical methods.