

COMPLYING WITH NEW MEDICARE REPORTING REQUIREMENTS APPLICABLE TO LIABILITY INSURERS AND SELF-INSURERS

(FORC Journal: Vol. 20 Edition 2 - Summer 2009)

Frederick J. Pomerantz, Esq.
(212) 490-3000

Introduction

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)¹ amends the Medicare Secondary Payer Act (MSPA)², by imposing significant new reporting obligations upon insurers and other qualified Responsible Reporting Entities (RRE) subject to it. The objective of the new reporting requirements, which are *effective July 1, 2009*, is to permit Medicare to track the resolution of liability claims involving incurred, and future, medical costs that are subject to Medicare to ensure that those parties who are primarily responsible for payment of medical costs subject to Medicare pay those costs, rather than Medicare which is a secondary, rather than a primary, payer. By so doing, it is the intent of MMSEA to reduce overall costs to Medicare.³

Under the new law and associated regulations, all liability insurers (including self-insurers), no-fault insurers, workers' compensation insurers and group health plan arrangements (GHP) are required to determine whether any individual who files a claim against the insurer or any entity insured or covered by the insurer would be entitled to Medicare benefits. If so, the insurer must provide Medicare with that individual's identity and any other information that may be required by the Secretary of Health and Human Services (Secretary). This information must be furnished to Medicare within the time specified by the Secretary after the claim is resolved through settlement, judgment, award or other payment, regardless whether or not there has been an admission or determination of liability.

Penalties for Noncompliance

In keeping with its stated goals, the MMSEA imposes severe penalties for noncompliance:

If an insurer or other Responsible Reporting Entity fails to notify Medicare in accordance with these guidelines, a civil penalty of *\$1,000* per day will be charged per claimant.⁴

Not only are there substantial monetary penalties, but Medicare now has the right to audit. MMSEA provides no specific guidance regarding audit criteria or how an RRE will be selected for audit. Although it is contemplated, the Centers for Medicare & Medicaid Services (CMS), the federal agency which is responsible for collecting data from qualified Responsible Reporting Entities, has not yet published the identifiable factors which might make an RRE at risk for non-compliance.

Registration Requirements

The new requirements obligate an RRE to register on the secure website for Coordination of Benefits Contractor (COBC) appointed by CMS on or before September 30, 2009. An RRE includes not only liability insurers (including self-insurers), but also no-fault insurers, workers' compensation insurers and GHPs.

FEDERATION OF REGULATORY COUNSEL, INC.

Importantly, although the reporting obligation commences between January 1, 2010 (the date when electronic reporting will be enabled) and March 31, 2010, depending on when the RRE completes file testing, the required quarterly production report to be first submitted is *retroactive to July 1, 2009*, regardless of the date of the RRE's first assigned file submission window.

In addition, unlike liability insurers, for a GHP, reporting responsibilities became effective January 1, 2009.⁵

Public Policy Considerations

The purpose of the new law is to obligate those parties who are primarily responsible for payment of medical costs subject to Medicare to pay those costs, rather than Medicare itself. This has the potential to save Medicare billions of dollars and to reduce the large, and still growing, Medicare deficit.⁶

The new mandatory Section 111 reporting requirements are in addition to current methods for obtaining information regarding situations where Medicare is appropriately a secondary payer. They do not replace or eliminate existing obligations under the MSPA provisions for any entity. For example, Medicare beneficiaries who receive a liability settlement, judgment, award or other payment are obligated to refund conditional payments within 60 days of receipt. The Section 111 reporting requirements do not eliminate this obligation.

The new law thus not only imposes significant new obligations, but may also influence the settlement of workers' compensation claims as well, given the mandatory establishment of a Medicare Set Aside Account (MSA) to pay claims for future medical expenses arising out of a workers' compensation claim.⁷

By law,⁸ primary payers, and an entity that receives payment from a primary plan, are obligated to reimburse Medicare for conditional payments when it is demonstrated that a primary plan "has or had a responsibility" to make payment.⁹

Under the MSPA, Medicare is afforded broad enforcement rights on several levels. For example, Medicare has a direct right against all primary payers responsible for making payment and any entity that received a primary payment, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer.¹⁰

Medicare and Impact of the MMSEA

Medicare is the federal health insurance program for:

- People age 65 and older
- People under age 65 with certain permanent disabilities
- People of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

Overall, the MMSEA imposes strict reporting requirements whenever there is a recovery for a liability claim encompassing medical costs, including mental health treatment, subject to Medicare, including future costs, regardless of whether by settlement or judgment.

Which Insurers Must Register and Report

All insurers, including but not limited to alien, non-admitted insurers writing on an excess/surplus line basis, captive insurers and risk retention groups, who issue coverage, including no-fault insurance that pays for

FEDERATION OF REGULATORY COUNSEL, INC.

health care services resulting from injury to an individual in an accident, regardless of fault, must comply with the registration and reporting requirements where the injured party is a Medicare beneficiary and the *date of incident is on or after July 1, 2009*. A newly-organized liability insurer must be compliant just as any other insurer. It will be up to their attorneys to advise them of these requirements, and it is likely that the plan of operation of any new carrier will have to discuss its plan to comply with the MMSEA registration and reporting requirements.

Under the MMSEA, liability insurance (including self-insurance) is defined to be coverage that indemnifies, or pays on behalf of the policyholder or self-insured entity, against third party claims for negligence that results in injury or illness to an individual. Liability includes, among others, homeowners' liability, automobile liability, uninsured or underinsured motorist liability, product liability, malpractice liability and workers' compensation.¹¹ The key to determining whether a liability insurer must register is if there is a reasonable expectation that covered claims will be resolved that include a payment by the insurer for medical costs subject to Medicare. Medicare, and thus RRE submissions, extend to costs for physical injuries as well as mental health costs.

For purposes of RRE submissions, the term "*claim*" is used to refer to the overall claim for liability insurance (including self-insurance), no-fault insurance, or workers' compensation rather than a single claim for a particular medical item or service regardless of whether the coverage is first-dollar or the coverage is excess over another insurer or over a self-insured retention. Where there are multiple carriers involved in a settlement, reporting is necessary for each individual party under which there is a payment responsibility, not one per person. To date, it appears, based on CMS pronouncements, that all settlements, even those viewed as "nuisance value" settlements, must be reported.

"Self-insurance" is defined to include individuals/entities engaged in a business, profession, or trade to the extent that they have not purchased liability insurance coverage. This includes responsibility for deductibles.

Where an entity is self-insured for a deductible, but the payment of that deductible is made through the insurer, then the insurer is responsible for including the deductible amount in the amount it reports as a settlement, judgment, award, or other payment. Although the MMSEA does not address claims paid under a self-insured retention, caution may dictate these be reported whenever possible.

When Registration and Account Setup Must Be Completed

The registration process requires RREs to notify COBC of their intent to report data to comply with Section 111 of MMSEA. Registration by the RRE is required and must be completed before the testing between the RRE and the COBC can begin. Liability, no-fault and workers' compensation RREs must register on the Coordination of Benefits Secure Website (COBSW) from *now through September 30, 2009* using an interactive website designed for this purpose. Registration is currently accessible via <https://www.section111.cms.hhs.gov>. All submissions, both registration and reporting data submissions, will be received electronically on this website.

CMS also provides a guide to registration requirements at:
<https://www.cms.hhs.gov/MandatoryInsRep/Downloads/RegistrationOverview.pdf>.

It should be noted, however, that although the reporting obligation commences between January 1, 2010 and March 30, 2010, the quarterly production reporting that is required to be submitted is retroactive to July 1, 2009, regardless of the date of the RRE's first assigned file submission window.

In summary, CMS has established the following mandatory timetable for registration and initial reporting by RREs:

FEDERATION OF REGULATORY COUNSEL, INC.

- Now through September 30, 2009 all RREs register on the COBC secure website
- July 1, 2009 to March 30, 2010 RREs submit test records and correct any errors
- January 1, 2010 to March 30, 2010 each RRE submits its initial report according to an assigned file submission window.

Impact on Medicare Set Aside Requirements

Under the Medicare Secondary Payer Act (MSPA)¹², CMS already requires separate funding of a Medicare Set Aside Account (MSA) to pay for future medical expenses arising from a workers' compensation claim that would otherwise be eligible for coverage under Medicare. At its core, an MSA is a portion of settlement proceeds set aside, or allocated, to pay for future Medicare covered services. The MSA must be exhausted prior to Medicare paying for any future care.¹³

Importantly, CMS has explicitly stated that it does not presently obligate liability and other non-workers' compensation insurers to coordinate payment of an MSA if settlement does not involve a claim for future medical expenses arising out of a workers' compensation claim. As such, settlement of pure liability claims does not currently give rise to any requirement to fund an MSA. Currently, liability insurers, GHPs and other non-workers' compensation insurers normally do *not* need to fund an MSA as part of any settlement. Nevertheless, simultaneous settlement of liability and a workers' compensation insurer's obligations to cover future medical expenses may require an MSA. Given the often layered and overlapping relationship between settlement of liability and workers' compensation claims, an insurer must carefully consider any possible MSA funding requirements.

CMS must review and approve an MSA if the workers' compensation claimant is a Medicare beneficiary, or may become a Medicare beneficiary during the lifetime of the settlement, and the total settlement amount is greater than \$25,000. In addition, if the claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000, then the Medicare set aside arrangement must be reviewed and approved by CMS. Approval of any MSA application depends upon whether the settlement is "reasonable."

Conclusion

For practitioners of workers' compensation and liability insurance law, Medicare compliance, at least with respect to reimbursement of conditional payments, is nothing new. However, the new notice and reporting obligations of Section 111 of the MMSEA will have a significant impact on clients.

For practitioners of insurance regulatory law, notifying clients and assisting them to understand and comply with the new notice and reporting obligations and/or defending them against allegations of failure to comply and notices of the imposition of penalties will have a significant impact on clients.

While requiring reporting of all resolved liability claims encompassing medical costs subject to Medicare should enable the federal Medicare program to realize considerable savings is simple, compliance with MMSEA's requirements is not. The reporting format from a technical perspective requires an insurer not just to register as required, but also to determine if registration by an individual issuing company or for the company as a whole is best suited to it. In addition, insurers must now track all claims where Medicare is implicated, gather detailed information about a claimant, and report as required under the MMSEA in a specified, electronic format. With the detailed registration and reporting requirements, and strict time deadlines imposed by MMSEA, clearly an insurer must exercise diligence to avoid what can be costly civil

FEDERATION OF REGULATORY COUNSEL, INC.

finances.

Endnotes

1. Public Law No. 110-173.
2. Section 1862(b) of the Social Security Act, 42 U.S.C. §1395y(b).
3. The New York Times on May 13, 2009 reporting on the current recession, stated that the Medicare fund that pays hospital bills for older Americans is expected to run out of money in 2017, two years earlier than projected last year. Labor Secretary Hilda L. Solis noted that with 5.7 million jobs lost in the recession since December 2007, the government collects less in payroll taxes, a major source of funding for Medicare as well as Social Security.
4. 42 U.S.C. §1395y(b)(8)(E). This is in addition to any other penalties available under the law.
5. Although Section 111 of MMSEA also contains new amendments to MSPA regarding reporting by Group Health Plans, this article, due to space limitations, only discusses amendments applicable to liability insurers and self-insurers.
6. Quoting the trustees of Medicare and Social Security, the May 13, 2009 New York Times article, see above fn.3, reports that in coming years Medicare spending will increase faster than either workers' earnings or the economy overall.
7. The Centers for Medicare & Medicaid Services (CMS) has the right to seek recovery against any entity, including a beneficiary, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment, directly or indirectly, where a third party payer, rather than Medicare, should have paid injury-related medical expenses. A right of reimbursement exists whether or not the settlement acknowledges liability or the manner in which the settlement and release specifies disbursement is to be made. 42 U.S.C. §1395y(b) (2) (B) (iii) (2000 and Supp. 2004).
8. 42 U.S.C. § 1395y(b)(2)(B)(ii)
9. A primary plan's "responsibility" may be "demonstrated" by a "judgment" or "a payment conditioned upon a recipient's compromise, waiver and release." 42 U.S.C. § 1395y(b)(2)(B)(ii). A "settlement" or "contractual obligation" further evidences "responsibility" under the MSPA. *See* 42 C.F.R. § 411.22 (b)(3). It is important to note that this obligation applies "whether or not there is a determination or admission of liability." 42 U.S.C. § 1395y(b)(2)(B)(ii). Thus, even denied claims are included under the statute.
10. 42 C.F.R. § 411.24(g). Medicare also has a subrogation right, as well as rights of joinder and intervention. *See* 42 C.F.R. § 411.26.
11. 42 C.F.R. §411.50.
12. 42 U.S.C. § 1395y.
13. The MSPA provisions state that Medicare is always secondary to workers' compensation and other insurance, including no-fault and liability insurance. Medicare's authority to review liability settlements arises under the same law. 42 U.S.C. §1395y (b)(1) and (2).