Medicare Matters: Part I

A Look at Medicare's New Mandatory Insurer Reporting Requirements and How They Impact Litigants and Lawyers

by Stephanie Frazier Stacy & Jill Gradwohl Schroeder

Editor's Note: "Medicare Matters" is a three-part series addressing several of the ways in which Medicare's right to recover conditional payments can impact personal injury claimants, lawyers and insurance carriers. Part I of the series will discuss Medicare's new Mandatory Insurer Reporting Requirements and will highlight some of the ways in which these new reporting requirements will change the way personal injury claims are managed and settled. Part II of the series will discuss the challenges of settling personal injury claims when Medicare has made past conditional payments. And Part III of the series will address utilization of Medicare Set-Aside Trusts (MSAs) when settling personal injury claims in which Medicare may have a right to recover conditional payments in the future.

A Look at Medicare's New Mandatory Insurer Reporting Requirements and How They Impact Litigants and Lawyers

The most recent Medicare reform, Senate Bill 2499, didn't prompt contentious national debate over whether to change prescription drug coverage or modify Medicare benefits. Instead it was aimed at getting insurance companies to report certain payment information to Medicare. President Bush uneventfully signed Senate Bill 2499 into law on December 29, 2007, but it has taken awhile for the new legislation-known as the "Medicare, Medicaid, and SCHIP Extension Act of 2007"[1] and more commonly referred to as the "**MMSEA**"-to get the attention it deserves.

If you aren't yet familiar with the MMSEA you will be soon, because Section 111 of the Act[2] requires that all Liability insurers (including self-insurers), No-fault insurers, workers' compensation insurers, and group health insurers must report detailed information directly to Medicare ***each time a settlement, judgment, award or other payment is made to a claimant who is entitled to receive Medicare benefits***. Failure to comply with the reporting requirements carries a ***civil penalty of $1,000 per claim, per day***. The new reporting requirements will require

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insurance carriers to make substantial changes to the way they investigate and manage personal injury claims, and will make it even more critical for lawyers bringing and defending personal injury cases to be well-versed in the complex rules governing Medicare's Secondary Payer status.

A Quick History of Medicare's Right to Reimbursement

Since the early 1980s federal law has established Medicare as a "secondary payer" to other plans, including auto liability, general liability, workers' compensation and No-fault coverages (all of which are considered "primary payers").[3] The purpose of the Medicare Secondary Payer Act (or MSPA) was to limit the situations under which Medicare would be required to pay for medical services, and to allow Medicare to be reimbursed when a private insurance plan paid, or should have paid, for a claimant's medical services.

In 2003, Medicare's statutory right to reimbursement was made even stronger. Prompted by skyrocketing costs, Congress made changes to the MSPA as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003[4] (the MMA), in an effort to shift some of Medicare's costs to private insurers. The MMA-best known for providing prescription drug benefits-also contained less publicized provisions which significantly strengthened Medicare's secondary payer status, clarifying that Medicare is *always* a secondary payer whenever a primary insurance plan (including self-insurance) is available,[5] and making clear that Medicare can seek reimbursement from virtually any party who received a primary payment, including Medicare beneficiaries, attorneys, physicians and medical providers, state agencies or private insurers, and any primary insurance plan (even if the primary plan already paid the Medicare beneficiary or other party).[6] When seeking reimbursement of conditional payments, Medicare does not need to take into account issues of disputed liability or allocation, and is not bound by the terms of settlement agreements purporting to determine who will have responsibility for repaying conditional payments to Medicare.[7] Moreover, if Medicare is not reimbursed and initiates legal action to recover conditional payments, it is entitled to recover double damages, plus interest.[8]

Obviously, Medicare's ability to identify and recover conditional payments depends on knowing when primary plans have issued payments to, or reached settlements with, Medicare beneficiaries. Historically, there have been several laws and regulations in place requiring that Medicare be notified when it has made a primary payment for services which were, or should have been, paid by a third-party payer or primary plan.[9] However, in part because Medicare did not pursue blanket enforcement of the existing reporting requirements, and in part because there was no penalty for failing to report information to Medicare, the reporting requirements were largely ignored and Medicare lacked the information necessary to allow it to aggressively pursue recovery of conditional payments.

The recently enacted MMSEA represents an effort to put teeth into the mandatory reporting requirements with the goal of reinforcing Medicare's status as a secondary payer, and helping to secure Medicare's long-term financial viability by allowing it to more aggressively pursue recovery of conditional payments. While the goal is laudable, the impact of the MMSEA on the insurance industry and on Medicare beneficiaries is significant, and not yet fully understood.

A Primer for Lawyers on the New Mandatory Insurer Reporting Requirements

Those who rushed to read the provisions of the MMSEA after its enactment were frustrated to find the legislation did not specify what sort of information needed to be reported to Medicare or how the information was to be reported. Instead, the Centers for Medicare and Medicaid Services (CMS) were given responsibility for developing the details of what, when and how the Mandatory Insurer Reporting would be implemented.

Details as to how CMS intends to implement the MMSEA are still being developed and are being released by CMS in a piecemeal fashion, despite implementation dates which are fast approaching. While a comprehensive detailing of what insurance carriers must do to comply with the new Mandatory Insurer Reporting Requirements is beyond the scope of this article, it is important for litigants and lawyers to have a general understanding of the scope and impact of the new reporting requirements, because they will change the way claims are processed and will have an impact on litigants' ability to timely resolve injury claims. This article will provide a general summary of the new Mandatory Insurer Reporting Requirements, using information CMS has released as of February 1, 2009, with the caveat that CMS is expected to further revise its guidelines in the upcoming months.

Which Insurers Must Report Under the MMSEA?

The Mandatory Insurer Reporting requirements apply to all Group Health Plans, all Liability Insurers (including self-insurers), all No-fault Insurers, and all Workers' Compensation Insurers. These insurance carriers and self-insured entities are referred to by CMS as "Responsible Reporting Entities" or "RREs" for purposes of the MMSEA. With the goal of sweeping as many different lines of coverage into the reporting requirements as possible, CMS has defined "liability insurers" and "No-fault insurers" very broadly. Among the lines of insur-

ance subject to the Mandatory Insurer Reporting Requirements are auto liability, uninsured motorist, underinsured motorist, homeowners, commercial general liability, farm and ranch, medical malpractice and product liability coverages, as well as medical payments coverage under auto policies and premises liability policies, and Personal Injury Protection or "PIP" coverage. CMS has defined "Workers' compensation insurers" to include plans administered by a State or the United States to provide compensation to workers for work-related injuries and/or illnesses, including those funded directly by a self-insured employer or indirectly through an insurer.

What Triggers the Duty to Report Under the MMSEA?

Under the MMSEA, mandatory reporting is required whenever Responsible Reporting Entities "determine . . . a claimant (including an individual whose claim is unresolved) is entitled to [Medicare] benefits" and a payment is made to or on behalf of the claimant. Reporting is triggered without regard to whether Medicare benefits have actually been paid, and the duty to determine whether a claimant is "entitled to Medicare benefits" fall solely upon the RRE. Just how RREs are to go about determining whether claimants are "entitled to Medicare benefits" is not yet clear, but because the penalty for being incorrect and failing to report is $1,000 per day, per claim, insurance carriers are taking the task very seriously and have understandably been frustrated by the lack of guidance from CMS on how to reliably determine Medicare eligibility. Just identifying the potential pool of candidates is challenging because, under current law, Medicare entitlement may exist for any of the following individuals:

Any citizen age 65 or older who:

- receives or is eligible to receive Social Security benefits; or
- receives or is eligible to receive railroad retirement benefits; or
- worked long enough in a government job where Medicare taxes were paid (or had a spouse who did); or
- is a dependent parent of someone who worked long enough in a government job where Medicare taxes were paid; or
- is a lawfully admitted noncitizen who has lived in the United States for at least five years

Before age 65, Medicare entitlement may exist for any citizen who:

- has been entitled to Social Security disability benefits for 24 months; or
- receives a disability pension from the railroad retirement board and meets certain conditions; or
- has Lou Gehrig's disease (amyotrophic lateral sclerosis); or
- worked long enough in a government job where Medicare taxes were paid and meets the requirements of the Social Security disability program; or
- is the child or widow(er) age 50 or older, including a divorced widow(er), of someone who has worked long enough in a government job where Medicare taxes were paid and meets the requirements of the Social Security disability program; or• has end stage renal disease.

RREs already have begun revising their claims handling procedures to include gathering information designed to help them determine whether a claimant may be "entitled to Medicare benefits" such that the new Mandatory Insurer Reporting Requirements are triggered with respect to that claimant. RREs have suggested it would be helpful if CMS allowed limited "query access" to Medicare eligibility records for purposes of enabling RREs to make this important determination, but the scope and frequency of any query access which may be granted is not yet clear, and will depend on how CMS balances the need for insurers to gather correct information against the privacy rights of Medicare beneficiaries.

In addition to making a preliminary determination as to whether a claimant is entitled to Medicare benefits, RREs will also need to monitor a claimant's Medicare eligibility status throughout the pendency of the claim, because even if a claimant is not a Medicare beneficiary at the time the claim is opened, the Mandatory Reporting Requirements will be triggered if the claimant subsequently becomes eligible for Medicare at any time before the claim is finally resolved. For instance, if a 26-year old employee suffers a wrist injury for which an insurer has an obligation to pay ongoing medical expenses, the insurer may have to continue to check the claimant's Medicare eligibility on a monthly basis to determine whether its Mandatory Insurer Reporting obligation has been triggered. RREs balk at the prospect of having to perform monthly queries until the claimant reaches age 65, when Medicare eligibility is likely. CMS is currently seeking public input as to how it may reasonably preserve the primary payer's obligation to pay without requiring the primary payer to perform monthly queries for decades to determine whether the claimant has become eligible for Medicare.

Making matters worse, there currently is no "safe harbor" from the mandatory $1,000 per day/per claim penalty if a carrier incorrectly determines a claimant's Medicare entitlement status, and fails to report as a result. In light of this, establishing internal protocols and workflows for determining and documenting Medicare entitlement is an enormous challenge for carriers, with substantial risk. RREs have requested assurances from CMS that if they engage in due diligence to verify a

claimant's Medicare status, they will not be subject to the per diem penalty, and CMS claims to be developing a model form to document due diligence. However, until more clarity is provided by CMS regarding acceptable methods and standards for determining Medicare entitlement, it is assumed prudent insurers will err on the side of over reporting in order to avoid the hefty penalties imposed for noncompliance.

What Data Must Be Reported Under the MMSEA?

Currently, CMS has identified over 100 different data fields of specific information RREs will be required to gather and report to CMS under the MMSEA. Individual reports may not require completion of all 100 data fields, since the specific data which must be reported will vary depending on the nature of the claim and the type of coverage involved. However, the reporting requirements are onerous and time-consuming even in very simple cases and, as more baby boomers become eligible for Medicare, the number of injury claims which trigger the reporting requirements will continue to rise.

Certainly, gathering general information about claimants and their injuries has been part of traditional claims-handling practices for decades, but compliance with the new reporting requirements will require carriers to gather and report very specific data in a very specific format which has no particular bearing on the claim they are adjusting, and instead is designed to further just one goal: allowing Medicare to more accurately identify, and recover, conditional payments made to and on behalf of Medicare beneficiaries. For instance, among the 100 different data fields of information RREs will be required to gather and report, are:

> • The Social Security Number (SSN) and Medicare Health Insurance Claim Number (HCIN) of the injured party;
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> • The ICD-9 Diagnosis codes (up to 5 different codes) describing the alleged injury or illness, including the code corresponding to the body part allegedly injured;
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> • If the injury, illness or incident may have been caused by a particular product, then specific information on the product type, product name and product manufacturer is required, as well as a description of the type of harm allegedly caused by the product;
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> • The Federal Tax Identification Number (TIN) of the applicable insurance or self-insurance plan;
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> • The limit of liability and exhaust date for No-fault coverage;
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> • Specific information regarding the claimant's attorney and/or other representative, including the attorney's full name, address, phone number, firm name, and the attorney's Federal Tax Identification Number (TIN);
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> • Information regarding whether the RRE has ongoing responsibility for the claimant's medical expenses and if so, the date such responsibility terminates;
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> • Information regarding the dollar amount of the RRE's payment to the claimant (Note that RREs must report all settlements, judgments, awards or other payments made to Medicare beneficiaries, *even when legal liability is denied or unclear*. Even when only a portion of the settlement, judgment or payment is attributed to medical expenses-the entire sum must be reported to CMS, and there is no exception for *de minimus* or "nuisance" settlements-all must be reported); and
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> • In wrongful death cases, information on the claimant's estate, including the name, address and phone number of the personal representative or special administrator, and the estate's Federal TIN.

For those who are interested, a complete listing and description of the proposed data fields is available on the CMS website in the Interim Record Layout at: https://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPInterim120508.pdf

How Will Information Be Reported Under the MMSEA?

Mandatory Insurer Reporting will be electronic only-no paper will be permitted. RREs will be required to register, and submit reports, on-line by logging in to a secure web site which is currently under development.

When Will Mandatory Reporting Begin?

Under the MMSEA, the Mandatory Insurer Reporting was intended to be implemented in two stages, with Group Health Plans beginning to report on January 1, 2009, and Liability insurers (including self-insurers), No-fault insurers and workers' compensation insurers beginning to report on July 1, 2009. Because development and implementation of the MMSEA has taken more time than originally anticipated, CMS has modified the implementation timeline. Electronic registration for Liability insurers (including self-insurers), No-fault insurers and workers' compensation insurers will begin May 1, 2009, and run through June 30, 2009. Each RRE will be assigned a technical representative from CMS to help establish appropriate protocols for the exchange of electronic reporting information. There will be a designated "testing period" from July 1, 2009 to September 30, 2009, and actual reporting for all RREs is scheduled to begin on October 1,

2009. For an overview and description of the registration process as currently envisioned by CMS, refer to: www.cms.hhs.gov/MandatoryInsRep/Downloads/RegistrationOverview.pdf

It is important to be aware that while CMS has indicated actual reporting will not begin until October 1, 2009, the effective date of the MMSEA remains January 1, 2009 (for Group Health plans) and July 1, 2009 (for Liability, No-fault and Workers' Compensation insurers). Consequently, beginning January 1, 2009 (for Group Health Plans) and beginning July 1, 2009 (for Liability, No-fault and Workers' Compensation carriers), RREs must be gathering the data elements required by CMS even though the information may not be reported until October 1, 2009.

How Often Will Mandatory Reporting Be Required?

The frequency of the required reporting varies depending on whether the payment issued is a single payment, or one issued as part of an ongoing obligation. Insurers and self-insureds are required to report on a "one-time" basis in cases where there is a single settlement, judgment, award or other payment made to a Medicare-entitled claimant, and are required to report on an "ongoing basis" for non-contested claims.

How will the Mandatory Insurer Reporting Requirements Impact Litigants and Lawyers?

Although the MMSEA places the heavy burden of reporting (and the hefty penalty for not reporting) solely upon private insurance carriers and self-insured entities, the ripple effect of the new reporting requirements will be felt by litigants and by the lawyers who file and defend personal injury claims. It is too early to predict all the ways in which personal injury litigation may be affected by the Mandatory Insurer Reporting Requirements, but early prognosticators have suggested the MMSEA will significantly increase the administrative costs of managing and resolving personal injury claims, may create delays in the claims process while mandatory information is gathered, and could have a chilling effect on settlements.

To comply with the new Mandatory Insurer Reporting Requirements, many carriers will be required to hire and train additional staff whose sole job responsibility will be managing the ongoing reporting obligations under the MMSEA. Many carriers will be required to purchase additional computer hardware and software for the sole purpose of managing ongoing reporting requirements under the MMSEA. All insurance carriers will significantly alter and expand existing claims procedures, and will experience notable increases in the administrative cost of managing and adjusting injury claims, directly in response to the burdens imposed by the MMSEA. Predicted increases in the administrative costs of adjusting personal injury claims in the wake of the MMSEA could translate into higher insurance premiums, with no commensurate increase in benefits to the injured claimant or to the insured who purchased the coverage-it is only Medicare that arguably will benefit from the increased administrative costs imposed on private insurers by the MMSEA.

Very early in the claims process, injured claimants and their lawyers will be asked to provide specific and detailed information to carriers and self-insured entities to enable them to meet their obligations under the MMSEA. If it is determined by the carrier that the claimant is entitled to Medicare, delays are inevitable because additional specific information must be gathered in advance of any payment, in order for the carrier to be in a position to timely report the required data elements to CMS once a payment is made. Claimants who are reluctant to disclose private medical and tax information may experience additional delays in claims processing as a result. While failure to cooperate with a carrier's efforts to gather additional information could delay payment of benefits under the policy, or may jeopardize the availability of first-party coverage if the failure to cooperate results in prejudice to the carrier, insurance carriers have correctly pointed out that there is no statute or regulation which *requires* Medicare beneficiaries to cooperate with private insurers' efforts to gather the data they are required to report under the MMSEA. Existing Federal Regulations do require Medicare beneficiaries to cooperate with *Medicare* in actions to recover past conditional payments (see 42 C.F.R. § 411.23(a)) and CMS representatives have suggested this regulation can be interpreted to require that beneficiaries also must cooperate with insurers' efforts to gather information for purposes of the Mandatory Insurer Reporting requirements, but the extent to which Medicare beneficiaries will voluntarily cooperate with private insurers' efforts to comply with the MMSEA remains to be seen.

Because there is no mandatory reporting required unless a settlement, judgment, award or other payments is made to a Medicare beneficiary, it has been suggested that the new Mandatory Insurer Reporting Requirements could have a chilling effect on settlements generally, and particularly on *de minimus* or nuisance-value settlements in questionable liability cases. Ironically, this would mean that while the goal of the MMSEA was to increase Medicare's ability to recover conditional payments, it may have the practical impact of reducing the number of settlements from which that recovery may be sought.

Finally, for those practitioners who may have taken lightly issues concerning Medicare's right to recover conditional pay-

ments in personal injury cases, the time has come to pay attention. Later this year, Medicare will be aware of every dollar paid to a Medicare beneficiary as a result of a settlement, judgment, award, or other payment, and will be more aggressively seeking reimbursement of its conditional payments. It will be even more critical for lawyers bringing and defending personal injury cases to be well-versed in the complex rules governing Medicare's Secondary Payer status. To learn whether you need to consider changing the way in the way you handle and settle personal injury claims involving Medicare beneficiaries, stay tuned for Medicare Matters, Part II.

Endnotes

1. Public Law 110-173
2. 42 U.S.C. § 1395 y(b)(8)
3. Omnibus Reconciliation Act of 1980 (Public Law 96-499); 42 U.S.C. § 1395y
4. Public Law 108-173
5. See 42 C.F.R. § 411.20
6. See 42 C.F.R. § 411.24(g)
7. See 42 C.F.R. § 411.22
8. 42 C.F.R. § 411.24
9. See, e.g. Omnibus Reconciliation Act of 1980 (Public Law 96-499); Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173); 42 C.F.R. § 411.25; and 42 C.F.R. § 489.20(f) and (g)