Medicare's Mandatory Reporting Requirements & Their Anticipated Impact on the Insurance Industry

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It is 2000 and Molly, a Medicare recipient, is involved in a car accident through no fault of her own. As a result of the accident, Molly sustains a lower back injury and incurs $50,000 in medical bills, all of which are paid by Medicare. Molly settles directly with the liability insurance carrier for $100,000 and executes a release of all claims, promising to pay any and all "liens" directly out of her settlement proceeds. Molly knows Medicare paid for her treatment; however, she is not aware of any claim of lien by Medicare. Subsequently she spends the entire $100,000 on her home mortgage, her grandchild's college tuition, and a new car. Molly's case slips through the cracks, and Medicare never discovers the medical claim made by Molly with the insurance company or the settlement of $100,000. Molly and her grandchild live happily ever after, and the insurance carrier closes its file.

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In 2011, these facts will result in a different outcome for both Molly and the insurance carrier. The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (also referred to herein as the "mandatory reporting requirements") requires insurance companies to electronically report to Medicare any settlement, judgment, award, or other payment made to a Medicare beneficiary, as well as any assumption of or termination of a responsibility to pay for a Medicare beneficiary's medical expenses. Presumably, Medicare will use the reported information to recoup past conditional payments and prevent unnecessary future payments which are the responsibility of another entity. In Molly's situation, if the settlement occurred in 2011, the insurance carrier will be required to electronically report to Medicare that it paid Molly $100,000 for the settlement of her claim. Medicare may then seek reimbursement for the $50,000 in conditional payments. If Molly spent the $100,000 and cannot reimburse Medicare, the federal government has the right to seek reimbursement directly from the liability insurance carrier. In other words, the insurance carrier could have to pay an additional $50,000 to Medicare, even though it already paid Molly $100,000 and closed its file.

Since insurance companies bear this risk for exposure if conditional payments are not properly reimbursed, affirma-

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tive measures must be taken to ensure Medicare is reimbursed out of payments made to Medicare beneficiaries for medical claims. The federal government enacted this statute to prevent Medicare from missing reimbursement opportunities, and a significant increase in reimbursement requests by Medicare should be expected upon the commencement of the mandatory reporting provisions of the MMSEA. (Although this article focuses on the mandatory reporting requirements and the reimbursement of past conditional payments, it is important to note that prior to any settlement, the parties must also carefully consider Medicare's potential interest in medical payments that may be made following settlement of a claim. Consideration of these "future interests" of Medicare, however, is a topic deserving of a separate article.)

The MSP and Path to the MMSEA

The Medicare Secondary Payer Act (MSP) prohibits Medicare from making medical payments if a "primary plan" has the responsibility to pay for such treatment. 42 U.S.C. § 1395y(b). A primary plan is an insurance plan (liability, workers' compensation, auto liability, and no-fault) covering an injured individual, and a "primary payer" is an entity responsible for making payments under the primary plan. 42 U.S.C. § 1395(y)(b)(2). In situations where the primary payer has not made a medical payment and is not expected to make the payment promptly, the MSP permits Medicare to pay for the injured individual's medical treatment, with the understanding that such payment is conditioned upon reimbursement once the primary payer's responsibility for that payment is demonstrated. *Id*. These payments by Medicare are referred to as "conditional payments."

The MSP specifically requires primary plans to "reimburse the appropriate Trust Fund for any payment made by [Medicare] if it is demonstrated that [the] primary plan has or had a responsibility to make payment with respect to such item or service." *Id*. The statute further explains that a primary plan's "responsibility" for payment can be demonstrated by a judgment, a payment made towards a compromise settlement, waiver or release (regardless of whether there has been a determination of liability), or by "other means." *Id.* Accordingly, in a situation where Medicare has made one or more conditional payments and a payment from the primary payer to the injured Medicare beneficiary is made through settlement, judgment, award, med-pay or other payment, the federal statutes require that Medicare be reimbursed for its conditional payment(s) once the primary payment is made.

If Medicare is not reimbursed, Medicare can seek reimbursement through a direct right of recovery from any party who *received* proceeds from the primary payer, including the claimant, claimant's attorney, medical providers, state agencies, and private insurers, or from entities that are *responsible* for making payment, including employers, insurance carriers, third party administrators (TPAs), employer group health plans, and entities relying on self-insurance. 42 C.F.R. § 411.24(e), (g). When seeking reimbursement directly from a primary payer, Medicare disregards the fact that the primary payer already paid the beneficiary. In fact, the MSP expressly requires the primary payer to reimburse Medicare for the conditional payment made for medical treatment despite the fact that the primary payer has already paid the beneficiary or other party for such medical treatment. 42 C.F.R. § 411.24(i). If Medicare has to take legal action to recover for its claim from the primary payer, Medicare has the right to seek double damages, or double the amount of the Medicare payments. 42 C.F.R. § 411.24(c)(2). Federal statutes confer Medicare with rights of subrogation, intervention, and joinder in addition to its right to reimbursement, to round out its recovery abilities. 42 U.S.C. § 1395y(b)(2)(B)(iv).

As demonstrated by these federal statutes, Medicare has an absolute right to be reimbursed for conditional payments and has the ability to seek reimbursement from almost all involved parties. However, while the language of the MSP provides for nearly complete recovery capabilities, prior to the enactment of the MMSEA, one crucial component impacting Medicare's ability to enforce its statutory rights was missing – awareness of a pending insurance claim. Obviously, Medicare cannot seek reimbursement for conditional payments if it has no knowledge of primary payer responsibility. Prior to implementation of the MMSEA, the only "notice" requirement was found in 42 C.F.R. § 411.25, and it required primary payers to provide notice to Medicare if it was demonstrated to a primary payer that "CMS has made a Medicare primary payment for services which the primary payer has made or should have made." 42 C.F.R. § 411.25. However, this notice requirement does not contain a specific enforcement mechanism or penalty for noncompliance, and as a result, has been largely ignored. As discussed in greater depth below, the passage of the MMSEA has effectively cured the notice problems previously hindering Medicare's enforcement capabilities, which will allow Medicare to ensure that no further reimbursement opportunities are missed.

Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)

The Medicare Secondary Payer Mandatory Reporting Provisions of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 require responsible reporting entities (RREs) to (1) determine whether a claimant is entitled

to Medicare benefits, and (2) electronically report to Medicare payments made to Medicare beneficiaries as a result of settlements, judgments, awards or other payments, or upon an assumption or termination of an ongoing responsibility for a Medicare beneficiary's medical expenses. 42 U.S.C. § 1395y(b)(7), (8). Electronic reporting takes place between the RRE and the Medicare Coordination of Benefits Contractor (the COBC) and is scheduled to begin in 2011.

• Who is responsible for reporting?

The "applicable plan" is responsible for reporting, and the insurance carrier of the "applicable plan" is referred to by Medicare as the "RRE." An "applicable plan" is defined in 42 U.S.C. § 1395y as "liability insurance (including self-insurance),""no fault insurance," and "workers' compensation laws or plans." Although it is clear from this statute that insurance companies are RREs, there are many unique insurance arrangements; as such, determining "who is the RRE?" can be a complicated question. For example, some insurance carriers use third parties to administer their claims. In these situations, the third party administrators (TPAs) are not RREs. An RRE "may contract with a TPA or other entity for actual file submissions for reporting purposes;" however, the RRE may not shift its reporting responsibility to a third party by contract or otherwise. (MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting, Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide (hereinafter referred to as "User Guide"), p. 22.) Therefore, if the reporting by the TPA is not accomplished properly, the RRE is held accountable despite a contract or agreement to the contrary.

Many entities are self-insured or have large deductible arrangements. For purposes of the MSP "where an entity engages in a business, trade, or profession, deductible amounts are self-insurance." (CMS Alert, dated February 14, 2010, at www.cms.gov/MandatoryInsRep/Downloads/NGHPAlertRREsWhoMustReport.pdf). A fully self-insured entity would pay the Medicare beneficiary directly and thus be responsible for reporting. (User Guide, p. 22.) However, "where the self-insurance in question is a deductible, and the insurer is responsible for Section 111 reporting with respect to the policy, it is responsible for reporting both the deductible and any amount in excess of the deductible." (CMS Alert, dated February 14, 2010.) In other words, "[t]he deductible is not reported as "self-insurance;" it is reported under the applicable policy number." *Id.* The alert further notes, however, that "[i]f an insured entity engages in a business, trade, or profession and acts without recourse to its insurance, it is responsible for Section 111 reporting with respect to those actions." *Id*. Neither the alert nor the User Guide defines "without recourse," but the following example is provided:

> A claim is made against Company X which has insurance through Insurer Y. Company X settles the claim without informing its insurer. Company X is responsible for Section 111 reporting for the claim regardless of whether or not the settlement amount is within the deductible or in excess of the deductible.

Id. Although not 100% clear, it appears that fully self-insured entities and entities paying claims "without recourse" to their insurance policies are considered "RREs." In deductible arrangements, however, where the payment is pursuant to an insurance plan and will ultimately impact that insurance plan, the insurer (or carrier of the plan) is the RRE. *Id*.

In claims involving re-insurance, stop loss insurance, excess insurance, umbrella insurance, guaranty funds, patient compensation funds, etc., "which have responsibility beyond a certain limit, the key in determining whether or not reporting for 42 U.S.C. § 1395y(b)(8) is required . . . is whether or not the payment is to the injured claimant/representative of the injured claimant vs. payment to the self-insured entity to reimburse the self-insured entity." Id. In the latter situation, the self-insured entity is the RRE, and the insurer paying the self-insured entity a reimbursement amount is not required to report. *Id*.

In situations where government agencies are tasked with directly resolving and paying claims, the government agencies are the RREs. If the government designates a carrier to resolve and pay claims with government funds, but without government review and/or approval, the designated carrier is the RRE. (User Guide, pp. 23-24.) If the government agency designates a carrier to resolve and pay claims using government funds, but retains review or approval authority, the government agency is the RRE. (User Guide, p. 23-24.) Obviously, these examples do not reflect an exhaustive list of complex insurance arrangements, and additional guidance can be found in Medicare's User Guide and the subsequent alert dated February 14, 2010.

• How does an RRE determine whether a claimant is Medicare eligible?

An RRE does not have to report settlements, judgments, awards or other payments, or an assumption/termination of an ongoing responsibility to pay medical expenses unless the transaction involves an individual entitled to Medicare benefits. The MMSEA places an affirmative obligation on the RRE to determine if the individual receiving payment or medical treatment is eligible for Medicare benefits, and the User Guide specifically instructs RREs to "implement a procedure in their claims review process to determine whether an injured party is a Medicare beneficiary and gather the information necessary for Section 111 reporting." (User Guide, p. 19.) In an apparent effort to assist RREs with the identification of Medicare beneficiaries, Medicare established a query system designed to run claimant data submitted by RREs

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through the Medicare database. If a match between the claimant and Medicare data occurs, Medicare will respond to the RRE with the Health Insurance Claim Number (HICN) of the Medicare beneficiary and "other updated information for the individual found on the Medicare Beneficiary Database." (User Guide, p. 19.)

To use this system, RREs must include in their query the HICN or social security number, name, date of birth, and gender of the injured party. The insurance industry expressed concern with obtaining private information from claimants and in response, Medicare provided a sample form to be sent to claimants annually for execution. (This form can be found at www.cms.gov/MandatoryInsRep/Downloads/RevisedHICNSSNForm081809.pdf.) The form requires claimants to provide certain pertinent information regarding their Medicare status and gives the claimant the opportunity to refuse to provide the requested information. Medicare declared it will "consider the reporting entity compliant for purposes of its next Section 111 file submission" despite a claimant's failure to supply the information if (1) the RRE obtains a signed copy of the sample form from the claimant; (2) the sample form is re-signed and dated at least once every 12 months in cases where an ongoing responsibility for payment of medicals applies; and (3) the reporting entity retains this documentation.

• What information is reported by the RRE?

RREs are required to report payments to Medicare beneficiaries as a result of settlements, judgments, awards, or other payments. The "Total Payment Obligation to the Claimant" (TPOC) is the term Medicare uses to refer to the actual dollar amount the RRE pays on behalf of the Medicare beneficiary as a result of the settlement, judgment, award, or other payment. The TPOC date is the date the payment obligation was established, which means the date the release was signed or court approval was obtained for settlements requiring court approval. If there is no written agreement, then the TPOC date is the date of payment. (User Guide, p. 149.) Claims are reported on "a beneficiary-by-beneficiary basis, by type of insurance, by policy number, by RRE, etc." As such, there may be more than one record from an RRE for an individual in a certain quarter. (User Guide, p. 84.) For example, if a Medicare beneficiary involved in a car accident makes a med-pay claim and then subsequently settles her claim with the same insurance carrier, then there will be two reportable TPOCs. (User Guide, p. 84.) In addition, if two insurance carriers make payments on behalf of one Medicare beneficiary for settlement, then each insurance carrier (RRE) would separately report their settlement with that beneficiary to Medicare. (User Guide, p. 84.) Medicare makes clear that if medicals are claimed and/or released, RREs must report TPOCs in their entirety regardless of any allocation made by the parties or determined by the court. (User Guide, p. 85.)

RREs are also required to report any assumption or termination of an ongoing responsibility for medical expenses (ORM). The date for the ORM is the date when the decision is made to assume responsibility for ongoing future medical expenses for the Medicare beneficiary. (User Guide, p. 75.) When there is an ORM, the RRE does not report each payment separately as a TPOC, but rather reports the assumption of an ORM and, if applicable, the subsequent termination of an ORM. (User Guide, p. 75.) Reporting for ORMs must occur regardless of whether there is a separate TPOC as a result of a settlement, judgment, award or other payment. (User Guide, p. 75.) Medicare emphasizes that "[i]t is critical to report ORM claims with information regarding the cause and nature of the illness, injury or incident associated with the claim" since Medicare will use the information to determine what medical services/items should be paid by the RRE versus Medicare. (User Guide, p. 75.) It should also be noted that payment for a one time defense medical evaluation does not have to be reported so long as this payment is made directly to the provider or physician providing the evaluation. (User Guide, p. 85.)

Medicare has also announced interim thresholds for reporting purposes, which allow RREs to omit certain claims from their reporting submissions for a specified period of time. These claims include (1) workers' compensation medical only claims involving an ORM where the file submission is due before December 31, 2011, and where the claimant loses no more than seven days from work and the medical expenses (which do not exceed $750) are paid directly to the medical provider; (2) TPOC dates prior to January 1, 2012, in amounts of $0 - $5,000; (3) TPOC dates of January 1, 2012, through December 31, 2012, in amounts of $0 - $2,000; and (4) TPOC dates of January 1, 2013, through December 31, 2013, in amounts of $0 - $600 (User Guide, pp. 52-53.)

• When do RREs report?

In 2011, RREs will submit an initial claim file and then subsequent quarterly file submissions during their assigned window each quarter. The initial claim files must include all payments as a result of settlements, judgments, and awards, and other payments to Medicare beneficiaries where the TPOC date is October 1, 2010, or later, as well as all claims in which an ORM exists as of January 1, 2010. Many carriers have already started updating their systems and working on the data compilation process in anticipation of this first

submission.

• What is the penalty for not reporting?

The penalty for non-compliance with the MMSEA is $1,000 per day per claimant. Funds received due to penalty payments will be deposited into the Federal Hospital Insurance Trust Fund, which finances Medicare Part A. 42 U.S.C. 1395y(b)(7), (b)(8).

• Where Do We Go from Here?

With the implementation of the MMSEA, Medicare will have everything it needs to know about primary payer responsibility and has stated it will begin to regularly seek reimbursement of conditional payments following settlements, judgments, monetary awards, and payment of medpay or PIP benefits. This is especially problematic in the context of settlements and final judgments since the general practice following payment of any settlement amount or judgment is to close the file and ship it to storage. Accordingly, insurance clients need to be aware that a conditional payment letter seeking reimbursement may follow months later, and clients should plan accordingly.

Back to Molly's hypothetical. A well-informed insurance carrier would treat the claim differently upon learning of Molly's beneficiary status. In this case, assume WI (Well-Informed) Insurance is the relevant insurance carrier and upon learning of Molly's beneficiary status, immediately obtains the pertinent information to provide Medicare with notice of Molly's claim (including Molly's social security and HICN numbers). Upon retrieving that information and obtaining a signed release from Molly, the adjuster forwards formal correspondence to Medicare's Coordination of Benefits Contractor advising of the claim and requesting a conditional payment investigation. Within eight weeks of the notice, the parties receive an interim conditional payment amount, which gives the parties an idea of the cost of the treatment paid by Medicare as of the date of the ledger. After confirming the ICD-9 codes match up to Molly's low back injury, the adjuster puts the conditional payment letter in the file and monitors Molly's treatment. As Molly's treatment stabilizes, the adjuster either follows up with Medicare directly or requests a print out of the conditional payment status directly from Molly, who is able to pull up the printout via her link on the mymedicare.gov website. Upon determining the most updated interim amount, the adjuster explains to Molly that they can reach a settlement figure but the conditional payment lien must be paid out of the settlement, and WI Insurance must hold the settlement funds until receiving a final conditional payment lien letter. The adjuster must either convince Molly to settle even though she will not know the final amount she will receive until after the settlement is finalized and the lien paid, or WI Insurance must agree to reimburse Medicare, regardless of the amount of the lien and bear the risk that the amount could be more than shown in the interim ledgers.

In this case, assume Molly and the adjuster monitor the treatment well and are fairly confident the conditional payment amount will be between $40,000 and $50,000. Assume further that Molly agrees to settle for $100,000 with the understanding that Medicare will be reimbursed before she receives her final amount. WI Insurance reports the settlement to Medicare, requests a final lien amount, and Medicare responds by advising the final amount is $50,000. WI Insurance pays $50,000 to Medicare, $50,000 to Molly, and closes its file. Pursuant to the MMSEA, WI Insurance electronically reports the $100,000 settlement with Molly to Medicare in WI Insurance's next quarterly file submission. Since the $50,000 has been paid, Medicare does not seek additional reimbursement. In this scenario, the adjuster, WI Insurance, and Molly live happily ever after without pulling files from storage, paying additional funds, or receiving a Medicare collection notice. Of course, this hypothetical assumes that everyone complies with their obligations under federal law and that Medicare operates in a timely fashion and according to its internal procedures. However, it remains to be seen whether these assumptions will continue to be the exception rather than the rule.

Furthermore, many claims are not as clear cut as Molly's claim, particularly when they are denied due to a dispute in liability or damages. For example, assume there is strong evidence that Molly's own negligence contributed to her injuries, and WI Insurance settles Molly's claim for a compromised amount of $20,000. In this situation, WI Insurance has acknowledged "responsibility" for $20,000 of Molly's claim by virtue of payment of its settlement funds, and Medicare, which made conditional payments of $50,000, would be entitled to the entire $20,000 settlement (minus procurement costs). WI Insurance would have an obligation to confirm that Medicare is reimbursed. If WI Insurance fails to comply with that obligation, WI Insurance may be required to reimburse Medicare regardless of whether it already paid Molly. Logically, however, if WI Insurance insists on reimbursing Medicare out of Molly's settlement, there will be no money left for Molly, and Molly may have no incentive to settle.

Denied and disputed claims are prevalent in the insurance industry and interesting issues surrounding compromised settlements in cases involving Medicare beneficiaries will continue to flood the desks of defense attorneys. Regardless of whether a claim is accepted or denied, when dealing with a Medicare beneficiary, the best strategy includes a prompt conditional payment investigation (the Medicare Secondary Payer Recover Contractor website can be found at www.msprc.info), consistent communication with the opposing side, and a collective effort from both sides to ensure Medicare's interests are protected in any resolution.

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Parting Comments of the YLC Chair

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King

What an honor and a privilege to serve as Chair of the Young Lawyers Committee ("YLC") this past year! The YLC has been hard at work on several different projects, a few of which I highlight. One of our first projects was the annual book drive which was held during the 2009 Fall Seminar at the Grandover Resort & Conference Center in Greensboro. This book drive was initiated several years ago by Carla Cobb, who practices in Raleigh, under the leadership of past YLC Chair Chad Bomar, who practices in Bermuda Run. Previously, we have donated books to several worthy organizations, including Motheread, Inc. For the 2009 book drive, Bonnie Refinski-Knight connected us with the Little Red Bookmobile, a small nonprofit organization located in New Bern. Nikki Ingianni, a New Bern resident, started this nonprofit organization approximately five years ago after purchasing a red bookmobile on eBay and driving it from Alabama to New Bern. Although she started with just a few books, the book donations have increased, and now she takes the bookmobile into neighborhoods of lower socio-economic classes for after-school tutoring and reading programs. Thanks to each of you who contributed to this and past book drives.

The Executive Board of the YLC met on October 20, 2009, at the Bar Center in Cary. This meeting was well attended and resulted in three YLC subcommittees being formed: (1) Education/CLE, (2) Membership, and (3) Communications.

The Communications Subcommittee was co-chaired this year by Scott Adams of Winston-Salem and Jonathan Bumgardner of Raleigh. Scott and Jonathan did a tremendous job with this subcommittee and have led the YLC to contributing articles for issues of The Defender.

The Membership Subcommittee was chaired by YLC Vice-Chair Doug Grimes from Charlotte, Jefferson Moeller from New Bern and Michael Barnette from Hickory. This subcommittee did a terrific job and brainstormed about ways to increase membership, including increasing participation at the annual meeting. The Membership Subcommittee is also discussing and developing regional networking events throughout the state.

The Education/CLE Subcommittee was chaired by J.T. Mlinarcik from Raleigh and included Kelli Burns from Charlotte, Jenny McKeller from Rocky Mount and Laurie Miller from Raleigh (Laurie is also the DRI/YLC liaison from North Carolina). This subcommittee went far beyond the call of duty and worked diligently, developing two upcoming CLE programs. The first CLE program, "Friend or Frenemy: Social Media's Direct Impact on Your Practice," will be held on Thursday, September 30, 2010, the day prior to the Fall Seminar, at the Grandover Resort & Conference Center in Greensboro. Included in this seminar are presentations regarding "Tips, Tricks & How To's of LinkedIn & Facebook," "Ethical Limitations & Implications of LinkedIn & Facebook," and "Making it Work: Using Social Media in Your Practice."

The second CLE/Seminar program, "Not Just Blowing Smoke, Using Oral Advocacy To Bring Home the Bacon," will be held at the UNC Kenan-Flagler Business School, Rizzo Conference Center, in Chapel Hill, on February 18, 2011. Topics for this CLE/Seminar include "Hearing Preparation: Not Getting Smoked in Front of Your Client, Your Opponent, and the Judge," "Out of the Frying Pan into the Fire – Handling Questions or Silence from the Judge," "Adding Flavor to the Meat of Your Argument – Effective Rebuttals," and "Where's the Beef – Powerful Use of Demonstrative Evidence." Attendance at this CLE/seminar will be limited to maximize individualized attention during the practice breakout sessions wherein each participant will have an opportunity to receive real-time in person evaluations, coaching, and feedback.

I encourage all members, especially our younger members, to attend these two CLE programs.

As you can see, the YLC has been quite busy this year. I extend special gratitude to Vice-Chair Doug Grimes, to J.T. Mlinarcik, to Laurie Miller and last, but by no means least, to Lynette Pitt, without whom any of this would have been possible.

It is time for me to pass the baton to my successor, Doug Grimes, who will do a fantastic job in his role as Chair of the YLC this coming year. Thanks for allowing me this most rewarding opportunity, thanks to the law firms for allowing their young attorneys to devote time and energy to these projects, and thanks to all YLC members for your participation and assistance.

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