

Medicare Secondary Payer Reporting Requirements Continue to Evolve

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Federal law provides that, under certain circumstances, a private insurer has primary responsibility to cover health expenses of a Medicare beneficiary. Historically, the Centers for Medicare and Medicaid Services (CMS) has not had access to information about payments made to Medicare beneficiaries that include amounts attributable to health care services previously paid by Medicare, or likely to be paid in the future. Therefore, in many instances, Medicare may have paid for services that should have been paid by the beneficiary (out of settlement proceeds) or by the primary payer under the Medicare Secondary Payer (MSP) rules. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Section 111) added new mandatory reporting requirements for insurers that are intended to enable CMS to ensure that it has the necessary information to determine when Medicare's financial responsibility is secondary. This article summarizes some of the key MSP requirements and recent developments relating to non-group health plans (NGHPs), which include liability insurance (including self-insurance), no-fault insurance and workers' compensation.¹

Overview of MSP Requirements for NGHPs

On December 5, 1980, Congress enacted the Medicare Secondary Payer Act, codified as amended at § 1862(b) of the Social Security Act (42 U.S.C. § 1395y(b)) (the MSP Act), which makes Medicare the secondary payer to various other payment sources. The MSP Act prohibits Medicare from making payment if payment has been made or can reasonably be expected to be made by a "primary plan," which includes group health plans, workers' compensation plans, liability insurance (including a self-insured plan), and no-fault insurance. The MSP Act obligates primary plans to pay primary to Medicare for any medical costs covered by the primary plan.

A secondary payer generally pays the balance of a claim only after the primary plan has paid. However, the MSP Act authorizes Medicare to make conditional payments to the provider when the primary plan has not made or is not expected to make payment promptly. In the case of a liability insurer, conditional payments are made by Medicare when payment is not made by the insurer within 120 days, which permits the healthcare provider to submit a claim for reimbursement to Medicare. Conditional payments are conditioned upon reimbursement to Medicare if it is demonstrated that the primary plan has or had the responsibility to make primary payment. Such responsibility may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services

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included in a claim against the primary payer or the primary payer's insured, or by other means. CMS is empowered to seek recovery from a primary plan, even after the primary plan has made payment to settle a claim, if Medicare is not reimbursed by the recipient of the payment within 60 days. 42 C.F.R. § 411.24(h); *see Health Ins. Ass'n v. Shalala*, 23 F.3d 412 (1994) (upholding 42 C.F.R. § 411.24(h) as valid in an Administrative Procedure Act proceeding). However, 42 C.F.R. § 411.24(b) and (d) generally limit any recovery sought by CMS to the value of the total settlement, payment, or judgment amount minus procurement costs. *See also* MSP Manual, Ch. 7, § 50.5.2.2.

In return for making conditional payments, the MSP Act provides for a direct statutory right of recovery for CMS against the beneficiary, insurer or any entity that has received payment from the proceeds of the settlement or judgment:

In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.

42 U.S.C. § 1395y(b)(2)(B)(iii).

For example, under the MSP Act, if a Medicare beneficiary is injured in an automobile accident, Medicare pays secondary to any available automobile liability or no-fault insurance payments for the Medicare-covered medical costs incurred. Similarly, if a patient is injured (or alleges injury) by a health care provider, Medicare is a secondary payer for any Medicare-covered medical costs incurred and included in (or released by) a judgment or settlement. The health care provider's professional liability coverage is the primary payer. A provider's payment of a judgment or settlement of a liability claim is considered to be a self-insurance under the MSP rules, and in such circumstances, the provider itself is a NGHP. In such case, under the MSP rules, if the provider's payment includes Medicare-covered medical expenses, Medicare is entitled to recoup prior payments and to avoid any payment for future medical expenses that are covered by the settlement.

Section 111 NGHP Reporting Requirements

The Section 111 requirements do not change existing rules that determine whether Medicare or another payer is the primary or secondary payer with respect to a Medicare beneficiary. Rather, the purpose of these new rules was to enable CMS to ensure that it has the necessary information to determine when Medicare's financial responsibility is secondary, and therefore Medicare payments may be reduced or, if already paid, recouped. In addition to the above-described penalties relating to

failure to comply with MSP requirements, failure to comply with the Section 111 reporting requirements can result in penalties of up to \$1,000 per day per claim.

Health care providers that self-insure their professional liability risks or own a captive insurer that funds their professional liability risks are subject to the same reporting requirements as commercial professional liability insurers. Most hospitals and many other health care providers are self-insured or insured through a captive for at least a portion of their liability risks. Many of the questions about implementation of the Section 111 requirements have come from health care providers that now must implement the systems necessary for Section 111 reporting, as well as determine which payments are reportable.

In order to comply with the Section 111 reporting requirements, NGHPs will be required to take four steps, briefly described below:

1. **Identify the RRE:** "Responsible reporting entity" (RRE) is the term used by CMS to describe the entity responsible for reporting under Section 111. In general, the RRE is the entity that makes payment to the claimant or a representative of the claimant, regardless of whether a third party (such as a captive insurer) reimburses the self-insured entity. For example, if a hospital makes payments to professional liability claimants and is then reimbursed by its self-insurance trust or captive insurer, the hospital is the RRE. Captive insurance policies written by captive insurers owned by hospitals or hospital systems, particularly those written by offshore captives, typically provide that the captive indemnifies the hospital for payments previously made to a claimant. Therefore, many hospitals or their parent companies will be RREs. Few offshore captives will be RREs, although CMS has now implemented changes to the registration process to accommodate foreign RREs.
2. **Register:** The RRE is required to register with CMS. Registration is completed online on a secure website (www.section111.cms.hhs.gov).
3. **Test:** Once registered, the RRE must also successfully undergo file submission testing, which involves submission to CMS and approval of test files using one of three submission formats.
4. **Report:** On a quarterly basis, the RRE must identify claimants that are Medicare beneficiaries and submit a report where a beneficiary's claim is fully or partially resolved through settlement, judgment, award or other payment during the applicable reporting period. An RRE may not limit or transfer the Section 111 reporting responsibilities, but may contract with an unrelated third party, such as a third party administrator, to prepare and file reports to CMS as its agent. In the case of professional liability settlements, even if the settlement agreement provides that the payment is limited to lost income or other non-medical expenses, if medical expenses are claimed by the claimant or are released by the claimant, the payment still must be reported. CMS is not bound by an allocation of medical expenses made by the parties.

Recent Section 111 Developments

On February 22, 2010, CMS issued a revised NGHP User Guide. The revised User Guide includes several significant changes. Most importantly, CMS extended the reporting deadlines applicable to NGHPs, stating that RREs are not required to begin

submitting reports until the first quarter of 2011, and need not report one-time payments (TPOCs) that occur before October 1, 2010.

In addition to the revised User Guide, on February 24, 2010, CMS also issued three Alerts for NGHPs that address certain open issues. One open issue is whether hospital write-offs and other payments made outside a formal insurance or self-insurance program are reportable. An example of this is where a Medicare beneficiary who is a patient suffers a fall out of a hospital bed, and the hospital makes the determination to waive the cost of any care provided as a result of the fall without any claim being filed against the hospital. CMS has received many questions on this issue, and the first Alert acknowledges that these issues are yet to be addressed. The Alert states that CMS has delayed until publication of further guidance reporting of medical write-offs, risk management activity, and clinical trials where the sponsor has agreed to pay for items or services related to injuries or complications. However, CMS also states that RREs should continue to identify and track these claims and payments so that they can be reported upon issuance of further guidance.

The second Alert clarifies NGHP RRE compliance requirements and discusses some of the basic registration, testing and reporting requirements applicable to RREs, focusing on providing step-by-step instructions on the four-step process highlighted above: identification of the RRE, registration, testing, and submission of actual quarterly reports.

The third Alert provides information on how an entity can determine if it is a NGHP RRE. This Alert finalizes some of the draft proposed RRE language from a previously issued July 2009, draft, and includes the following:

- A parent corporation may register on behalf of a subsidiary, but a sibling corporation may not register for another sibling, and a subsidiary may not register for a parent.
- A deductible which is part of the insurer's limit should be reported by the insurer (so no double reporting), while a self-insured retention (SIR) that is not part of the insurer's coverage limits should be reported by the insured as an RRE.
- For fronting arrangements, the entity that pays claims is RRE.

New Initiatives

Even as CMS attempts to clarify the Section 111 requirements, new legislative efforts are under way that may reshape the some of the underlying issues. On March 9, 2010, Representative Patrick Murphy (D-PA) introduced H.R. 4796, the Medicare Secondary Payer Enhancement Act of 2010, into the U.S. House of Representatives. H.R. 4796 was introduced with support from the Medicare Advocacy Recovery Coalition, an insurer and employer group that advocates for improvements in the Secondary Payer program. H.R. 4796 is currently in the early stages of the legislative process, having last been referred to the House Energy and Commerce Committee on March 9, 2010. H.R. 4796 proposes several changes to the Medicare Secondary Payer Act (MSP Act) and to reporting under Section 111 of MMSEA.

The proposed changes to the MSP Act are intended to provide more certainty to claimants and applicable plans regarding potential MSP liability. The most significant proposed change is to permit claimants and NGHPs to voluntarily submit proposals to CMS 90 days prior to settlement, judgment, award or other payment that could trigger Section 111 reporting which would be binding upon CMS for the value of any potential MSP recovery that may occur with regard to the claim in question. Other proposed changes to Section 111 reporting would require CMS to implement a Section 111 reporting process that excludes the reporting of health insurance claim numbers and Social Security numbers, mandate that CMS provide conditional payment letters within 120 days of the request, and set a statute of limitations on MSP recovery actions at three years following submission of the Section 111 report. Significantly, the proposed Act would also modify the current Section 111 penalty provisions to provide the government with discretion to impose penalties, and require the U.S. Department of Health and Human Services to develop safe harbors for meeting reporting requirements.²

Nevertheless, regardless of whether some version of H.R. 4796 is enacted, the Section 111 reporting requirements will remain a powerful tool to identify potential MSP recoupment opportunities for CMS as well as circumstances where CMS can avoid making payment for claims that should be paid from the proceeds of a liability settlement or other payment. Recent events have indicated that CMS intends to pursue such opportunities aggressively. For example, on December 1, 2009, in *United States v. Stricker et al.*, United States District Court, Northern District of Alabama, CV-09-PT-2423-E, the United States Department of Justice (DOJ) filed suit against the former defendants, plaintiffs' attorneys and insurers that were involved in a \$300 million settlement that involved some release for medical costs, seeking reimbursement of conditional Medicare payments it made to approximately 900 Medicare beneficiaries. The DOJ is seeking double damages from the insurers and defendants pursuant to the MSP Act, and direct recovery from the plaintiffs' attorneys. In light of this more aggressive stance, NGHPs must take particular care to address Medicare's interests pursuant to the MSP Act when structuring settlements with Medicare beneficiaries.

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¹ Medicare is also secondary to certain group health plans (GHPs). GHPs present traditional coordination of benefits issues, while NGHP reporting raises more difficult and unanswered questions, particularly for health care providers that self-insure all or part of their general and professional liability coverage. The Section 111 reporting requirements are already effective for GHPs.

² Above three paragraphs: MWE, "HR 4796 Proposes Modifications to Medicare Secondary Payer Recovery and Reporting Requirements," http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object_id/f8bc549b-610c-4b23-8870-0fd844fdf0ab.cfm (last visited May 7, 2010).