



MEDICARE SECONDARY PAYER RULES AND MANDATORY REPORTING PROVISIONS



BALCH & BINGHAM LLP
Alabama • Georgia • Mississippi • Washington, D.C.

I. BACKGROUND

- Medicare is a federal program that provides healthcare benefits to:
 - (1) people age 65 and over;
 - (2) those under age 65 with certain disabilities; and
 - (3) anyone with end stage renal disease (“ESRD”).
- Oversight of the Medicare program is provided by the Centers for Medicare and Medicaid Services (“CMS”), an agency of the federal government and a part of the U.S. Department of Health and Human Services (“HHS”).
- Medicare is a costly program, and as such, the government is continually implementing measures to reduce (or restrain the growth of) costs.

II. MEDICARE AS A SECONDARY PAYER

A. In General

- When Medicare was enacted in 1965, it was the primary payer for all Medicare beneficiaries.
- In 1980, Congress enacted Section 1862(b) of the Social Security Act, known as the Medicare Secondary Payer (“MSP”) provisions.
- Medicare became the secondary payer, rather than the primary payer.
- The purpose of the MSP rule was to shift costs from the Medicare program to private sources of payment.

Medicare is a secondary payer to Group Health Plans (“GHPs”) for certain groups of individuals, as follows:

- Working Aged: Individuals age 65 and older and who have GHP coverage on the basis of their own or their spouse’s current employment with an employer that has at least 20 employees;
- Disabled: Individuals who are younger than age 65 and disabled and who have GHP coverage on the basis of their own or a family member’s current employment with an employer having at least 100 employees; or
- Permanent Kidney Failure: Individuals suffering from ESRD and who have GHP coverage on any basis.



Medicare is also a secondary payer to certain types of non-Group Health Plan (“non-GHP”) insurance coverage, including:

- Liability insurance (including self-insurance);
- No-fault insurance; and
- Workers’ compensation insurance.

Medicare is precluded from paying for a beneficiary’s medical expenses when payment “has been made or can reasonably be expected to be made” from another source.

B. Conditional Payments

- Medicare can pay for a beneficiary's covered medical expenses as a conditional payment.
- Payment is conditioned on reimbursement to Medicare out of the proceeds of any third party liability settlement, award, judgment, or recovery.
- This conditional payment is made if it is determined that the liability or no-fault insurer will not pay "promptly".

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- “Promptly” is defined as within 120 days from (1) the date a claim is filed with an insurer or a lien is filed against a potential liability settlement, or (2) the date service was furnished, or, for inpatient hospital services, the date of the hospital discharge.
 - Any judgment, or any payment that is conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) will trigger the requirement to reimburse Medicare.
 - In order to recover a conditional payment, CMS can bring an action against all entities (insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a GHP, or large GHP, or otherwise).

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- Recovery can also occur from any entity that has received payment from a primary plan. Thus, CMS may:
 - Offset debts against future payments,
 - Refer debts to the Department of Justice, or
 - Bring an action to recover from a beneficiary, provider, supplier, physician, attorney, state agency or private carrier.

 - If payment is not received by Medicare, it can assess penalties, interest and double damages.

III. MANDATORY REPORTING

- On December 29, 2007, Congress passed Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (the "MMSEA").
- Section 111 of the MMSEA requires GHPs and non-GHPs to report to CMS's Coordination of Benefits Contractor ("COBC")
- Reporting is triggered when the insured entity makes a payment for a claim brought by a Medicare beneficiary.
- Reporting is done on a quarterly basis.

A. GHP Reporting

- **GHP RRES:** A GHP organization that must report under Section 111 of the MMSEA is defined as “an entity serving as an insurer or third party administrator for a group health plan...and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary.”
- On and after January 1, 2010, GHPs must report to CMS all instances of the GHPs making payment for a claim brought by a Medicare beneficiary.
- An employer offering GHP insurance coverage to employees will not be a RRE, but its GHP insurer or third party administrator will be the RRE.
- An employer should cooperate with its GHP insurer or third party administrator to provide prompt and accurate information regarding beneficiary status.

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- Also subject to GHP reporting:
 - Health Reimbursement Arrangements (“HRAs”)
 - American Indians
 - Alaskan Native Tribes

 - GHP RREs may use agents to submit data on their behalf (i.e., data services company, consulting company).

 - Even if an agent is utilized, the RRE remains solely responsible and accountable.

B. Non-GHP Reporting

- **Non-GHP RREs:** Non-GHP RREs include plans, laws and arrangements and the fiduciary or administrator for plans, laws and arrangements such as:
 - Liability insurance (including self-insurance)
 - No-fault insurance
 - Worker's compensation

- Non-GHP RREs must report on all claims where the injured party is or was a Medicare beneficiary and the claims are addressed or resolved (or partially addressed or resolved) through a settlement, judgment, award or other payment with a total payment obligation to claimant ("TPOC") exceeding the reporting thresholds.

- RREs must also report claim information where ongoing responsibility for medicals ("ORM") related to a claim was assumed on or after January 1, 2010.

- Mandatory reporting requirements apply only to TPOCs in excess of the threshold amount.
- Current thresholds are merely interim thresholds while CMS implements the Section 111 reporting process:

<u>Last TPOC Date</u>	<u>Threshold</u>
Prior to 1/1/2012	\$5,000
1/1/2012 – 12/31/2012	\$2,000
1/1/2013 – 12/31/2013	\$ 600
1/1/2014 or thereafter	None

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- Where a RRE has multiple TPOCs involving the same claim and the same claimant, those amounts must be aggregated to determine if the threshold amount is met.
 - If the RRE has an ongoing responsibility for the beneficiary's medical costs, then there is no threshold, and all payment amounts must be reported.

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- Risk management write-offs (including a reduction in the amount due as a risk management tool) are considered self-insurance for the purposes of the Medicare Secondary Payer provisions.
 - Example: Payment or write-off by a Physician directly to a claimant (e.g., to avoid reporting to the National Practitioner Data Bank) requires reporting under Section 111.
 - According to CMS, entities must report the write-off or value of the property provided as a TPOC from liability insurance (including self-insurance) if the value exceeds the current threshold.

C. Consequences of Noncompliance

- Failure to comply with the reporting requirements may subject an RRE to a fine of \$1,000 per day for each day of noncompliance, for each individual for whom the information should have been submitted.
- The \$1,000 per day fine is in addition to any other penalties Medicare is entitled to impose, including interest and double damages recoverable under any Medicare Secondary Payer claim.
- Mistakes can be costly!

D. Appeal Rights

- Penalties for non-compliance with MSP reporting rules can be appealed under the Civil Monetary Penalty Statute, 42 U.S.C. § 1320a-7a(e).
- A party has 60 days to petition the U.S. Court of Appeals for modification or set-aside of the penalties.

IV. WHAT SHOULD EMPLOYERS DO NOW?

- MSP reporting rules will affect all litigation where medical expenses are involved.
- For example, labor and employment claims with personal injury and related medical expense claims are impacted.
- The MSP law and MMSEA Section 111 reporting requirements could apply, even if the settlement documents and defendant expressly deny liability, and even if the plaintiff or the court subsequently states that there are no medical damages.

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- Keep Medicare's claims interest in mind during the negotiation and settlement process.
 - Medicare must be paid within sixty (60) days of receipt of proceeds from the third party.
 - In all pending claims where medical damages are alleged, the employer should discover information regarding the claimant such as the Social Security Number, Medicare eligibility, Health Insurance Claim Number ("HICN").
 - Employer should also seek releases from claimants to procure benefit and claims payment information from Medicare.
 - Defendant companies should also update discovery from time to time because a claimant ineligible for Medicare at the outset of litigation may become eligible before the case is resolved.



V. CONCLUSION

Although the MSP provisions and Section 111 of the MMSEA contain complex and technical rules, the key to compliance is knowing your obligations.

Knowledge is power!



Thank you!

Balch & Bingham LLP

Genie Stark Thomas

601-965-8177

gstarkthomas@balch.com

Jackson, Mississippi

Brent Cobb

205-226-3477

bcobb@balch.com

Birmingham, Alabama