ALSTON + BIRD LLP

Health Care ADVISORY

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New Medicare Secondary Payer (MSP) Reporting Requirements Set to Take Effect January 2011 for Many Personal Injury Defendants

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) impacts many businesses that make a settlement payment to a personal injury plaintiff. MMSEA[1] (a part of the Medicare Secondary Payer Rule) is applicable to group health plans,[2] liability insurers, (including self-insurers),[3] no-fault insurers[4] and workers' compensation carriers. MMSEA's new reporting requirements related to personal injury settlements are set to take effect in January 2011.

This advisory provides background information on the Medicare Secondary Payer Rule, an overview of Section 111 of MMSEA and guidance on what actions must be taken by entities required to report under the MMSEA.

What Is the Medicare Secondary Payer Rule and How Can It Affect Settlements?

The federal statutes governing Medicare include a complicated section known as the Medicare Secondary Payer (MSP) rule, which was originally passed in 1980. The MSP rule states that Medicare will be a secondary payer in the event that certain other types of insurance plans or payers (identified as "primary payers") are available to pay a Medicare beneficiary's medical costs.[5] These primary payers include workers' compensation plans, certain group health plans, products liability insurance, no-fault insurance, automobile liability insurance and general liability insurance, including "self-insured" liability plans.

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[1] 42 U.S.C. § 1395y(b)(7)&(8).

[2] A group health plan is "a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families." 26 U.S.C. § 5000(b)(1).

[3] "An entity that engages in a business, trade, or other profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part." 42 U.S.C. 1395(b)(2)(A)(ii). Self-insurance or deemed "self-insurance can be demonstrated by a settlement, judgment, award, or other payment to satisfy an alleged claim (including any deductible or co-pay on a liability insurance, no-fault insurance, or workers' compensation law or plan) for a business, trade or profession." *See* 42 U.S.C. §§ 1395y(b)(8)(C).

[4] No-fault insurers include insurers that pay medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners and commercial plans. It is sometimes called "medical payments coverage," "personal injury protection" or "medical expense coverage." This definition is available at 42 C.F.R. § 411.50.

[5] The definition of primary plan includes any entity that settles a personal injury claim with a Medicare beneficiary, regardless of whether the entity admits liability for the injury. *See* 42 U.S.C. § 1395y(b)(2)(B)(ii).

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One of the most controversial aspects of the MSP rule involves its definition of "self-insurance" as including any private company that settles a lawsuit by paying "out of pocket" (i.e., without making a claim against the company's insurance carrier). This means that private settlements of personal injury claims made by Medicare beneficiaries, even if they include no admission of fault by the company, would be subject to the reporting and repayment obligations described herein, as well as the related penalty provisions.

The MSP rule applies any time there is a primary payer (including a self-insurer) that covers payment of a judgment or settlement related to a claim made by a Medicare beneficiary for past or future medical expenses. In those cases, Medicare would be considered the secondary payer and, to the extent it pays for medical care for the person involved, it would have a right to recover at least a portion of the settlement funds being paid by the primary payer. The amount that Medicare could recover from a primary payer is capped at the amount of medical expenses paid by Medicare. However, Medicare has taken the position that it is not bound by a settlement agreement allocation that states a certain percentage or dollar amount of the overall settlement is attributable to medical expenses.

For settlements involving (1) employer group health plans (GHP), (2) workers' compensation plans and (3) no-fault insurance, if Medicare is not reimbursed within 60 days of the settlement payment, the party that ***made the payment*** must reimburse Medicare, even if it has already reimbursed the beneficiary or other party.[6] In other words, if the party making a settlement payment is one of the three entities listed above and it makes a settlement payment to a Medicare beneficiary who received Medicare covered medical care as a result of the injury in question (i.e., the plaintiff), then Medicare can seek to recover from the payer directly, ***even if*** the plaintiff has already received the settlement proceeds.

For other types of primary payers (e.g., "self-insured" entities, including a company that pays a settlement out of pocket), this same rule applies if the payer ***is, or should be, aware*** that Medicare made a payment on behalf of the plaintiff.[7]

Medicare may recover up to (a) the amount of medical expenses paid by Medicare, or (b) the amount of the settlement, whichever is less. This could, in certain circumstances, require a primary payer to pay twice (once to the plaintiff and once to Medicare) and then be forced to sue the plaintiff to attempt to recover the payment. Furthermore, failure to make payments as required under the statute and regulations may also result in the imposition of interest.[8]

What Is MMSEA?

MMSEA is a 2007 amendment to the MSP rule. In the past, there was a perceived difficulty with enforcing the MSP rule because Medicare lacked mechanisms for determining when a personal injury suit by a Medicare beneficiary resulted in the beneficiary receiving a settlement or judgment. As a result, Congress passed MMSEA in an attempt to reduce federal healthcare costs by ensuring that funds paid by primary payers (including funds paid to settle personal injury lawsuits) are disclosed and the government has an opportunity to recover payments it made on behalf of Medicare beneficiaries.

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[6] 42 C.F.R. § 411.24(h) & § 411.24(i)(1).

[7] 42 C.F.R. § 411.24(i)(2).

[8] 42 C.F.R. § 411.24(c)(1).

Notably, MMSEA does not impose any new ***payment requirements*** on primary payers; those requirements existed previously under the MSP. MMSEA simply adds ***reporting requirements*** to ensure that all parties are complying with the existing payment requirements.

MMSEA Reporting Requirements for Liability Insurers (Including Self-Insurers), No-Fault Insurers and Worker's Compensation Carriers[9]

The new requirements in Section 111 mandate that when paying claims for personal injuries, private payers (referred to by MMSEA as Responsible Reporting Entities, or RREs) are required to determine if the claimant is a Medicare beneficiary. If so, the RRE must report to CMS the beneficiary's coverage under settlements, judgments or other payments from liability insurance, no-fault insurance or workers' compensation. If the claimant is ***not*** a Medicare beneficiary, no further action is required by MMSEA.

Failure to comply with the mandatory reporting requirements may result in a fine of $1000 per day per claimant.[10]

Under the MSP rule and the new reporting requirements, an RRE making a payment directly to a Medicare beneficiary pursuant to settling a personal injury claim is generally required to report and make payments to Medicare in two situations: (1) when medical expenses ***previously incurred*** by the beneficiary are claimed or released as part of the settlement, or (2) the RRE agrees to assume any ***on-going responsibility*** for the medical expenses of the beneficiary.[11]

Section 111 categorizes settlements and judgments as either total payment obligation to claimant (TPOC) or ongoing responsibility for the claimant's medical expenses (ORMs). The former category is capped by the amount actually paid by the primary payer, while the latter is capped by the amount of future medical expenses affirmatively assumed by the primary payer. Express admission of liability or responsibility for the underlying injury is ***not*** required for the MSP requirements to apply. To the contrary, most settlement agreements include a specific disclaimer of any fault by the party making the payment; nevertheless, CMS may still have a claim under the MSP for some or all of the amounts paid.

The obligation to report TPOCs and ORMs arises at the time of the settlement or judgment. However, ORMs require an additional report. RREs must report when they ***first assume*** ongoing responsibility for a claimant's medical expenses and again when their obligations to pay the claimant's medical expenses ***cease***.[12]

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9 GHPs have separate reporting requirements and are not discussed in this advisory.

10 *See* 42 U.S.C. § 1395y(b)(7)(B)(i) and (b)(8)(E)(i).

11 MMSEA Section 111, Medicare Secondary Payer Mandatory Reporting, Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation USER GUIDE, Version 3.0 (Feb. 22, 2010) *available at* http://www.cms.gov/MandatoryInsRep/Downloads/NGHPUserGuideV3022210.pdf, at 10 [hereinafter MMSEA Section 111, Liability Insurance User Guide].

12 Liability insurers, no-fault insurers and worker's compensation carriers are required to register as RREs and go through an extensive testing process. After the testing process, the insurers and carriers are required to submit initial claims files where the TPOC date is October 1, 2010, or subsequent, and that meet the threshold requirements described above. TPOCs with dates prior to October 1, 2010, do not have to be reported. Initial claims files must be submitted for ORMs as of January 1, 2010, and subsequent. These files will be updated on a quarterly basis.

The first step to complying with Section 111 is to register as an RRE with the Medicare Coordination of Benefits Contractor (COBC) through the Coordination of Benefits secure website at www.section111.cms.hhs.gov. At the conclusion of the registration period, there will be a mandatory testing period to ensure the efficacy of the reporting system.

All liability insurers, no-fault insurers and workers' compensation carriers are required to submit initial production claim input files ***beginning January 1, 2011***. This is the category that includes "self-insured" companies settling personal injury claims through out-of-pocket payments.[13] All RREs are encouraged to become familiar with the CMS Revised Implementation Timeline[14] and the CMS "MMSEA 111 What's New"[15] webpage for information on implementation dates, as these dates have already changed several times.

When determining whether to report a settlement or judgment, entities must consider whether the settlement or judgment meets the reporting thresholds. Noted below are interim threshold requirements. These thresholds are ***interim*** and in place while CMS implements the Section 111 reporting process. CMS has reserved the right to change these thresholds and will provide advance notice in the event of any changes.

Reporting Thresholds – TPOCs

When reporting settlements or judgments involving a TPOC (final settlement), the mandatory reporting requirement applies only to TPOCs that are ***in excess*** of the threshold amount.

- For claim reports where the last (most recent) TPOC date is prior to January 1, 2012, the threshold amount is $5,000.
- For claim reports where the last (most recent) TPOC date is January 1, 2012, through December 31, 2012, the threshold amount is $2000 per settlement.
- For claim reports where the last (most recent) TPOC date is January 1, 2013, through December 31, 2013, the threshold amount is $600 per settlement.
- For claim reports where the last (most recent) TPOC date is January 1, 2013, through December 31, 2013, the threshold amount is $600 per settlement.
- There are no minimum threshold amounts for claims where the last (most recent) TPOC is January 1, 2014, and after.

When an 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, but a TPOC that occurred prior to October 1, 2010, ***should not*** be included in the calculation to determine if the threshold amount is met.[16]

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[13] All GHPs were required to begin submission of production files on October 1, 2009.

[14] The Timeline is available at http://www.cms.gov/MandatoryInsRep/Downloads/RevTimeline032910.pdf.

[15] http://www.cms.gov/MandatoryInsRep/04_Whats_New.asp.

[16] MMSEA Section 111, Liability Insurance User Guide, *supra* note 11, at 52–53; requirements also apply to Workers' Compensation TPOCs.

Reporting Thresholds – ORMs

When settlements or judgments involve ORMs existing as of January 1, 2010, ***all payment amounts*** must be reported regardless of the thresholds described above.[17]

MMSEA Reporting Tips

Entities covered under MMSEA Section 111 should bear in mind the following when determining whether and what to report under the new MMSEA requirements.

- **Does the MSP Rule Apply?**

In order for the MSP rule to apply, the payer's responsibility for the payment must be demonstrated in some way, which could include a settlement, a judgment or a payment conditioned on a waiver or release from a claim against the primary payer.

- **Is the Entity an RRE?**

Whether or not an entity is considered an RRE does not affect the entity's underlying MSP obligation (to reimburse CMS as a Primary Plan), but does dictate if the entity has a reporting requirement under the MMSEA and is therefore subject to the potential fines for failing to report. The key element in making this determination is whether the entity makes a direct payment to a Medicare beneficiary as part of a settlement or judgment related to a personal injury.

- **Is the Claimant a Medicare Beneficiary?**

To determine if a claimant is a Medicare beneficiary, RREs should incorporate procedures into their claims assessment process to determine if the claimant falls into categories of persons eligible for Medicare. In litigation, RREs should inquire about Medicare coverage through discovery early on in the process. If the claimant is not a Medicare beneficiary (and not about to become one soon), then the MSP rule should not apply.

Section 111 of MMSEA is poised to impose significant and complicated new reporting obligations on many defendants involved in personal injury suits. For further information or assistance with the new reporting requirements, please contact any of the following attorneys in Alston & Bird's Health Care Group.

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[17] *Id.*, at 51–52.

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