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Navigating the Medicare Secondary Payer Mandatory Reporting Requirements

As we enter a new decade, it is incumbent upon employers and insurers to be familiar with their new obligations under the Medicare Secondary Payer Statute. Failure to adhere to recent amendments to the Statute will result in major financial penalties for employers and insurers of over \$1,000 per day, per claimant. This article aims to provide the reader with an easy to follow explanation of the recent changes to assist employers and insurers with timely compliance with the new requirements.

The Medicare Secondary Payer Statute, codified at 42 U.S.C. § 1395y, has been in effect, in some form, since the birth of Medicare in 1965. In 1980, the Statute underwent significant change when liability insurance (including self-insurance), automobile and no-fault insurance were added to the list of primary payers, which only included workers' compensation prior to the amendment.ⁱ With this change Medicare gained the ability to recover prior payments for medical expenses and decline payment for future medical expenses arising from injuries that were at issue in a liability claim. Under the Statute, Medicare's funds are preserved where another insurer has primary responsibility to Medicare. Preservation of Medicare's funds is critical now more than ever as the baby boomers reach eligibility age.

In 2007, the Statute underwent another round of significant amendments when Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and imposed mandatory reporting requirements on certain insurance companies and businesses. Collectively, these entities are referred to as "Required Reporting Entities" or "RREs" and include those administering liability insurance plans (including self-insurance), no-fault

insurance plans and worker's compensation plans. The analysis is complicated to determine whether an employer is an RRE and may vary among the states. As an RRE, an entity is required to determine whether a plaintiff/claimant is entitled to Medicare benefits on any basis, and upon settlement of a Medicare beneficiary's claim, submit all information required by the Centers for Medicare and Medicaid Services (CMS) with respect to the claimant to CMS.ⁱⁱ The newly enacted reporting requirements are triggered when a RRE has a payment obligation to a Medicare beneficiary for a claim possibly involving past or future medical expenses.

The first step toward compliance with the new amendment is for RREs to register. The registration period ended on September 30, 2009 and was "unofficially" extended until December 31, 2009. The registration process will provide a RRE with instructions for reporting deadlines. The next step is the testing requirements. RREs are required to conduct reporting system testing from January 1, 2010 through March 31, 2010.

RREs are required to submit their initial reports during an assigned window and thereafter on a quarterly basis. The reporting requirement commences during the second quarter of 2010 (April 1, 2010 through June 30, 2010). In addition to information specified by the CMS, the report must identify the Medicare beneficiary, whose illness, injury, incident or accident is at issue. With this information, the CMS can determine whether a recoverable claim exists.

The reporting requirements are divided in two categories: (1) Total Payment Obligations to Claimants (TPOCs) and (2) Ongoing Responsibility for Medicals (ORMs). For TPOCs, the obligation to report is triggered upon the settlement of a case. For an

ORM, the RRE will initially report when the ORM is assumed and will provide a second report when the ORM is terminated. The reporting requirements apply to settlements, judgments, awards and other payments made post-July 1, 2009 for ORMs and post-January 1, 2010 for TPOCs.

The new reporting requirements do not change the secondary payer rules, which have long been effect. Under the new reporting obligations, the CMS will have more information to ensure that Medicare makes payments in the proper order and to better enforce its existing rights as secondary payer.

In 1995, the Secondary Payer Statute gave rise to the use of Medicare Set-Aside Arrangements (MSAs) in workers' compensation settlements. While the 2007 amendments do not require the use of MSAs in liability settlements, it is becoming more common as Medicare's interests as a secondary payer must be reasonably considered in liability settlements pursuant to Medicare Secondary Payer Statute. Under the Statute, Medicare will be reimbursed for past medical expenses paid up until the date of settlement. It is recommended to resolve Medicare's lien on past medical expenses as part of the settlement or hold a portion of the funds in trust until the lien can be resolved. Where a settlement includes payment for future medical expenses, Medicare expects that a MSA will be in place to cover those future medical expenses. If it is clear that a plaintiff/claimant will have no future medical expenses as a result of an injury at issue in a lawsuit, a MSA will not be necessary.

The new reporting requirements will significantly impact RREs. The penalties for noncompliance will subject a RRE to a steep penalty of \$1,000 per day of noncompliance; per claimant. It is incumbent on a RRE to become acquainted with the MMSEA to avoid a penalty. The penalty is in addition to the primary payer's liability for a Medicare Secondary Payer

claim. One practical consideration for the RREs is the inevitable administrative costs to keep track of Medicare beneficiary claimants and when a reportable event occurs.

Please contact Nicolson Associates LLC for further information or with questions or comments about this Update.

ⁱ "Payment under [Medicare] may not be made . . . with respect to any item or service to the extent that (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance." 42 U.S.C. § 1395y(b)(2)(A)(ii)(2009).

ⁱⁱ 42 U.S.C. § 1395y(b)(8)(2009).

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