

Medicare's Evolving Reporting Requirements

BY GLENN SIMPSON; JOHN J. CAMPBELL; PAUL J. MASTERSON; RO BALTAYAN

Published 12/17/2009

[Magazine Subscription](#) | [Article Reprints](#)



Medicare's Secondary Payer Statute (42 U.S.C. §1395y) has existed in some form since the inception of the Medicare program in 1965. While the statute has been amended several times since then, the most significant amendments occurred in 1980, when the list of primary payers was expanded from workers' compensation only to also include liability, automobile and no-fault insurance; and in 2007, when the Medicare, Medicaid, & SCHIP Extension Act of 2007 (MMSEA) imposed significant reporting requirements on workers' compensation, liability and no-fault plans (including self-insured plans).

The 1980 revisions have, themselves, undergone changes over the years, but the following provision of the Medicare Secondary Payer statute has been in existence in substantially the same form since December 1980:

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.*

CMS interprets this language as providing that any settlement that closes out future medical expenses in a claim against a primary payer represents a situation in which "payment has been made" for an item or service otherwise covered by Medicare, precluding future Medicare coverage for those items or services until the payment has been exhausted on future medical expenses related to the injury. This provision of the Secondary Payer Statute gave rise to the use of the first Medicare Set-Aside Arrangement (MSA) in a workers' compensation settlement in 1995. This same provision also forms the basis for statements from several representatives of CMS over the past four years that Medicare's interests as secondary payer must be reasonably considered in liability settlements, just as they must be in workers' compensation

settlements. As a result, the use of MSAs in liability settlements is becoming more and more common.

New Deadline Set

The 2007 amendment to the Secondary Payer Statute, contained in Section 111 of the MMSEA, adds 42 U.S.C. §1395y(b)(8), which imposes strict information reporting requirements on liability insurance plans, no-fault insurance plans and workers' compensation plans, (including self-insurance), referred to collectively by the Centers for Medicare and Medicaid Services (CMS) as Required Reporting Entities or RREs.

According to MMSEA Section 111, RREs have the responsibility to:

1. Determine whether a plaintiff/claimant is entitled to Medicare benefits on any basis; and
2. Upon settlement of a Medicare beneficiary's claim, submit all information required by CMS with respect to the claimant to CMS.

While MMSEA Section 111 became effective on July 1, 2009, actual reporting under MMSEA Section 111 has been delayed until April 1, 2010, with regard to claims involving existing Medicare beneficiaries where there is a settlement, judgment or award on or after Jan. 1, 2010.

At that time, RREs will be required to submit required information on a quarterly basis. Penalties for non-compliance are stiff — \$1,000 per claimant for each day that the RRE is out of compliance. This penalty is in addition to any Medicare Secondary Payer claim for which the plan, as primary payer, may be liable.

The information that RREs will be required to submit is strikingly similar to the information currently required for submission and CMS review of MSAs in connection with workers' compensation settlements. This is a fairly clear indication that CMS intends to gather information to identify situations in which Medicare is a secondary payer and ensure that Medicare's interests as the secondary payer are reasonably considered in workers' compensation and liability settlements.

As a result, RREs are already instituting internal procedures for compliance with the new reporting laws, including procedures for determining the Medicare status of every claimant, collecting identifying information on all claimants when their claims are opened, and complying with the actual reporting requirements for claims that settle. RREs are also taking steps to ensure that, as primary payers, they reasonably consider Medicare's interests under the Secondary Payer Statute in any settlement involving a Medicare beneficiary.

A great deal of misinformation exists regarding the effects of MMSEA Section 111 on the use of MSAs in liability settlements. Some have stated that MMSEA Section 111 requires MSAs in liability settlements, effective July 1, 2009. Others have stated that

MMSEA Section 111 says nothing about MSAs in liability settlements and, therefore, MSAs are not needed in liability settlements. Both statements are incorrect. The Secondary Payer provisions that give rise to the use of MSAs in liability and workers' compensation settlements have existed for over 28 years. The new Secondary Payer provisions in Section 111 of the MMSEA provide a powerful tool by which CMS can now better enforce its existing rights as secondary payer.

Glenn W. Simpson, BS, MBA, JD, CPCU, is a vice president-operations at MGU Specialty Risk Services. He may be contacted at gsimpson@mguspecialtyriskservices.com. John J. Campbell, JD, CELA, MSCC, is the founder and principal attorney of the Law Offices of John J. Campbell, P.C. He may be contacted at jcampbell@jicelderlaw.com. Paul J. Masterson, AB, JD, is a vice president-operations at MGU Specialty Risk Services. He may be contacted at pmasterson@mguspecialtyriskservices.com. Ro Baltayan, CRC, CVE, CCM, CLCP, MSCC, is co-founder and developer of Medicare Allocations Inc., and is its principal MSA allocator. She may be contacted at rbaltayan@medicareallocations.com.