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## Medicare Secondary Payer Update

The Medicare Secondary Payer Act (MSPA)<sup>1</sup> is a game-changer for claims offices across the country. The additional reporting requirements required by the Federal Government and associated penalties for failure to report has caught the attention of employers - if not now, certainly by autumn 2010 when the rules take effect. What's interesting is the fact that these rules have been in place since 1981, but have largely been ignored by claims offices because enforcement focused on the Medicare beneficiary. No longer is that viewpoint widely held, and it appears that primary payers (insurance companies and self insureds that pay claims) are implementing new procedures to mitigate their MSPA exposure, which no doubt will add time and money to the cost of claims. Only time will tell how much this will really cost the industry.

### Reporting to Medicare

Most claims professionals are surprised they are saddled with two separate and distinct reporting obligations under the MSPA. The original obligation, 42 CFR §411.25, has existed since 1989 by regulation. The second reporting requirement, Section 111, has been a topic of discussion but has not been implemented yet. Implementation of Section 111 is scheduled for 2011.

#### 42 CFR §411.25

Under 42 CFR §411.25, primary plans are charged with notification to Medicare (in writing) when it has made or should have made primary payment for services when it is "demonstrated" to be a primary payer. The term "demonstrated" is defined within the MSPA as a judgment or a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability). In other words, if a primary plan intends to settle a claim, it must notify Medicare about it as soon as practical.

Why most primary plans are not familiar with this particular reporting requirement has to do with the lack of consequences for failing to comply. There are no immediate penalties unless Medicare becomes aware of the claim. But the potential impact is significant in that Medicare may ignore the settlement and require the primary plan to reimburse it for all medical expense it has paid related to the claim irrespective of the date the case was settled. This is exactly the situation in *U.S. v. Stricker*<sup>2</sup>, pending in the U.S. District Court for the Northern District of Alabama, where the U.S. Attorney is seeking repayment for all conditional payments made both before and after the settlement date. While final adjudication is still pending, *U.S. v. Stricker* still demonstrates Medicare's viewpoint on the importance of reporting. Keep in mind

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<sup>1</sup> See 42 USC §1395y(b)

<sup>2</sup> Civil Action No. CV-KOB-2423-E

that under this reporting requirement there are no thresholds<sup>3</sup>. All cases involving Medicare beneficiaries are to be reported, regardless of the amount or manner of resolution.

### Section 111 Reporting

The second reporting requirement, Section 111, is not yet implemented but has captured the attention of primary plans now for almost three years<sup>4</sup>. The new law establishes a penalty of \$1,000 per day for every claim not reported, which further demonstrates how serious Medicare is about collecting case information on settlements and judgments that should have been received under its regulations as noted above.

Section 111 is really meant to codify what Medicare attempted to do by its earlier regulation. It has gone a bit further, however, in that reporting must be done electronically. The Centers for Medicare & Medicaid Services (CMS) is charged with the administration of Medicare and implementation of the new law. Coordinating who has to report and "sizing the data" planned for submission has presented challenges for CMS resulting in delayed implementation of the law that was to go into effect on July 1, 2009.

Currently, CMS has set January 1, 2011, as the date registered primary plans (known as Responsible Reporting Entities or RREs) will begin submission of data to the Coordination of Benefits Contractor (COBC), a CMS contractor. With Section 111 reporting requirements still being finalized by CMS, the completion of the fourth version of the Section 111 User Guide is expected at the end of the third quarter of 2010. Notwithstanding, the start date is holding firm and primary plans should not expect the implementation date to slip any further.

There are two report triggers contemplated by Section 111 - Ongoing Responsibility for Medical (ORM) and Total Payment Obligation to Claimant (TPOC). Each has its own rules on time periods when data is to be collected. Therefore, it is important for employers to develop separate protocols within their claims administration offices for each reporting trigger.

No matter what line of business, if the primary plan takes on responsibility for medical expenses, then they also take on the responsibility to report to Medicare under Section 111. There is no data filed in Section 111 where you enter the "start date" of medical responsibility. Medicare presumes primary plan responsibility relates back to the accident or exposure date to increase its reimbursement claim. When a primary plan ends its responsibility for medical, that date must also be reported. In this situation, a data field for end date is provided and

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<sup>3</sup> 42 CFR §411.25 requires an insurance carrier or self-insured to notify Medicare when it has the potential to be or is responsible to pay a claim. The notification requirement pre-dates Section 111, which was not intended to amend or otherwise change the MSP rules that were in place. As such, the Section 111 thresholds for electronic reporting do not apply to the notification requirements under the previously issued regulations. H.R. 4796 intends to harmonize thresholds so it applies to all aspects of MSP.

<sup>4</sup> Section 111 as it is commonly referred to can be found at 42 USC §1395y(b)(8). It has other names and acronyms as well, being referred to as Mandatory Insurance Reporting (MIR) or Medicare & Medicaid State Children's Health Insurance Program Extension Act (MMSEA/Schip).

signals to Medicare that from that date forward they now resume primary payment responsibility for future medical items and services.

When Section 111 is implemented, there will be a large number of ORM claims to initially report. To manage that number, Medicare has adopted rules to minimize impact on primary plans limiting the period of look-back. The critical date for ORM is January 1, 2010. Primary plans need to report every case that was open or opened from that date forward with ORM. The accident date or exposure date is irrelevant. For example, a case that is open on January 1, 2010, with an accident date of May 15, 1991, will trigger ORM reporting. Furthermore, any case that is reopened after January 1, 2010, will also require ORM reporting. Consequently, claims administrators should already be collecting data for Section 111 submission on ORM claims.

The second trigger for Section 111 reporting is for TPOC. The rules here are easier. As of October 1, 2010, any settlement, award or judgment that exceeds a particular threshold is to be reported. The initial threshold of \$5,000 runs through the end of 2011. After that, it is halved to \$2,500 for 2012, \$600 for 2013 and zero thereafter. It is difficult to believe that Medicare will desire receiving information such as gift card settlements of \$5, but that is where Section 111 is presently headed.

### **Responsible Reporting Entity**

Who will report the data on primary plans that have registered with CMS? Not all primary plans are required to report. Only those that are considered Responsible Reporting Entities (RREs) are responsible and also have the burden of incurring the potential \$1,000 per day per claim penalty. Whether or not a primary plan is also an RRE is based upon the manner in which it has structured its risk program. If a primary plan is self-insured, it is also the RRE. However, if the primary plan has chosen to purchase a deductible program, irrespective of whether or not it is responsible for handling its own claims within the deductible, the insurance carrier is always the RRE. A captive cannot be the RRE, only its parent company. And then, its parent company is an RRE dependant on how it has structured its risk program with regard to insurance. Bottom line, if you have an insurance policy, the insurance company is the RRE with only one exception – fronting policies. If the primary plan has purchased a fronting policy, they remain the RRE.

It is important to understand that even though the primary plan is not an RRE, there is still MSPA exposure. A primary plan is the entity responsible for reimbursement to Medicare of conditional payments, not the RRE. Consequently, however the risk relationship is structured by the primary plan, careful attention must be given to the process by the claims administrators to make certain MSPA obligations are completed.

RREs are to begin reporting data to Medicare beginning January 2011. Reporting occurs once per quarter during an assigned week in the quarter. The RRE is given its assigned reporting period within the quarter after it has completed its Section 111 registration process. You are in compliance with Section 111 registration if: 1) the required registration process is complete, including submission of a signed profile; or 2) the primary plan has notified the

COBC of its inability to register during the initial designated time frame; and 3) the primary plan has subsequently registered at a later time arranged with the COBC that is approved.

To begin the registration process, go here:

[www.section111.cms.hhs.gov/MRA/LoginWarning.action](http://www.section111.cms.hhs.gov/MRA/LoginWarning.action).

### **Impact of Section 111 on Primary Plans**

Electronic reporting of all settlements, awards and judgments made to a Medicare beneficiary provides Medicare with the knowledge it needs to secure appropriate reimbursement of conditional payments. In the past, Medicare was entitled to reimbursement, but without knowledge, they had no way of perfecting that right. Reporting removes the last roadblock and it is definitely a game-changer for the claims administrator's workflow.

Primary plans that desire to mitigate its MSPA exposure must manage the MSPA obligation. No longer is it appropriate to lay this responsibility at the feet of the Medicare beneficiary or legal counsel. If the Medicare beneficiary or counsel fails to complete the obligation, the primary plan remains exposed for the obligation and potentially double damages to Medicare. ***The regulation makes the primary plan responsible to Medicare even though it has already paid the Medicare beneficiary.***

When the Medicare beneficiary does not complete the obligation, Medicare will refer the conditional payment debt to the Department of Treasury (IRS) for collection. The Treasury Department is empowered to levy tax refunds, grants, or any other funds owed to the primary plan to satisfy the debt.

In response, claims administrators have updated workflows to add steps to proactively manage the MSPA obligation. Some of the initial efforts have not worked out so well, such as adding Medicare to the settlement or adding the Medicare beneficiary's legal representative as an additional indemnitor to the settlement documents. In the case of adding Medicare to the settlement draft, initial case law has indicated that agreement by the Medicare beneficiary is required. (See *Tomilson v. Lander*, 2009 U.S. Dist. LEXIS 38683.) As for including claimant's legal representatives, thus far it is an ethics issue.

The best way for claims administrators to approach MSPA obligations is to work with the Medicare beneficiary or representative to submit the appropriate paperwork to Medicare. This can be done by either withholding or partially withholding proceeds until the Medicare obligation is understood, or receiving approval from the Medicare beneficiary to do it directly. Either way, the process is cumbersome and delays closure of the claim. However, a claims administrator can improve timelines by centralizing its Medicare processes. A dedicated group can consistently speak to Medicare's contractors and serve as the voice of the claim to both report and collect the data needed for reimbursement. Directly overseeing the MSPA process shortens time periods between settlement and case closure. It also provides an added measure of security that Medicare's obligations are satisfied, reducing potential action by Treasury.

### **ORM Issues for Primary Plans**

ORM will have a major impact on workers' compensation claims. Today, workers' compensation claims administrators deal with Medicare and its contractors when there is a decision to settle an industrial accident case. Since the claim has been handled for the most part before then, there is very little exposure for past medical expense and most of the time is spent on how to avoid shifting the future medical obligations arising from the settlement to Medicare. In that regard, Medicare Set Asides have become the accepted practice to satisfy Medicare obligations.

The reporting of ORM, however, will add a new wrinkle to workers' compensation claim administrators. After such information is reported, Medicare's contractors will research whether or not Medicare has paid for any past items or services that may be related to the case. If expenses are found, Medicare's contractor will issue a letter to the primary plan seeking reimbursement. Workers' compensation examiners will need to be familiar with this new process, as they will be paying Medicare in cases where no release or settlement is contemplated. There is also no right of administrative appeal by the primary plan, so it could be that medical services not even covered by the workers' compensation statute or plan may have to be paid and subsequent action filed in District Court to resolve the issue later. Potentially, this is a huge cost driver and the workers' Compensation claims administrator will need to be prepared for it.

### **Help is On the Way: Support H.R. 4796**

The MSPA has certain inequities as it is applied to primary plans. It is a law more than 30 years old with amendments over the years that were focused on improving case information flow to Medicare. But now that a connection has been achieved, and primary plans have had a chance to properly analyze the MSPA, it is clear that additional changes are needed or the claims resolution process will suffer significant delays.

In 2008, the Medicare Advocacy Recovery Coalition (MARC) was established to advocate for the improvement of the MSPA program for beneficiaries and affected companies, and to identify ways to legislatively correct the current statute. Formed by a group of entities in the regulated community, MARC has been developing strategic alliances with Congressional leaders and government agencies to focus on broader MSPA reform.

By June 2009, MARC organized a meeting of critical stakeholders from all parts of the industry to discuss possible solutions. H.R. 4796 is the legislative fix ultimately agreed upon. Although it does not solve all MSPA issues, it does include some important provisions all could agree on. Led by Congressman Patrick Murphy (D-PA) and Congressman Tim Murphy (R-PA), H.R. 4796 has picked up an additional 28 co-sponsors and had maintained bi-partisan support since introduction on March 9, 2010. The bill is under consideration by both the House Energy & Commerce Committee as well as Ways & Means.

H.R. 4796 supports the government's need to be promptly reimbursed by streamlining the process to allow parties the authority to estimate what may be owed Medicare.

If passed, H.R. 4796 will make the following enhancements to the MSPA:

1. Authorize Medicare to provide a final demand for conditional payments before a settlement;
2. Alternatively, authorize participants to a settlement to estimate the Medicare conditional payment and submit it to Medicare;
3. Establish a three-year statute of limitations from the date of the settlement or judgment;
4. Protect Medicare beneficiary privacy and eliminate the requirement to use a Medicare Health Insurance Card Number or Social Security Number;
5. Softening of Section 111 penalties;
6. Provide a right of administrative appeal for primary plans; and
7. Establish a threshold of \$5,000 for MSPA applicability.

Each enhancement will greatly assist parties attempting to resolve their MSPA liability. The ability to obtain a final number before settlement makes sense, and is consistent with claims workflows in place today. When a final demand follows a settlement, uncertainty is added to the process. If the Medicare beneficiary disagrees with the settlement because Medicare has asked for a larger share than anticipated, additional litigation or costs are injected into the process. Settlements need to be final and that can be accomplished by having Medicare's component clearly understood before the case is settled. That way, all parties know where they stand when a settlement is reached.

H.R. 4796 has a good chance for success, but there are a few roadblocks to overcome. First, is the fact that the 111<sup>th</sup> Congressional Session ends this year and thus time is an issue. Further shortening the time for Congress' consideration is the election year and sessions will be less frequent starting this fall as members hit the campaign trail. Finally, not having Senate companion legislation in place also presents a challenge.

MARC's membership is comprised of entities representing virtually every sector of the MSP-regulated community including attorneys, brokers, insureds, insurers, insurance and trade associations, self-insureds and third-party administrators. A key ingredient to legislative progress, however, is constituent support. Employers are encouraged to send a letter of support for H.R. 4796 to their Congressional leaders.

If not already members, employers are encouraged to explore MARC's Web site and review their accomplishments and goals to decide whether involvement meets their needs. For more information, visit MARC's Web site at [www.marccoalition.com](http://www.marccoalition.com) and click the link for MSPEA 2010 / H.R. 4796.

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### For More Information

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