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UPCOMING INSURER REPORTING REQUIREMENTS UNDER THE MEDICARE PROGRAM

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In previous issues of this publication, we have provided information about the Medicare Secondary Payer program. In a nutshell, the MSP program provides that the Medicare program is secondary to other available sources of payment for health care, including no-fault insurance, workers' compensation insurance, and liability coverage. It may make "conditional payments" if the other source does not pay right away, but it has a right of reimbursement from those sources.

We have noted in our articles that

- Medicare's interest takes precedence over any other requirement, including state-created or contractual limitations periods
- Payment of a settlement or judgment to a claimant cannot avoid Medicare's right of reimbursement

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- Medicare may recover its conditional payment from the claimant or from the insurer
- The insurer can, in some cases, be liable for double the amount owed to the claimant, under an expressly-created "private cause of action", perhaps in addition to the amount owed to Medicare.

Until recently, although there was always a recognized need to be aware of and to account for Medicare's interest when a case is settled or a judgment is paid, there was no affirmative obligation on the part of an insurer to make contact with anyone in the Federal government. That will soon be changing.

In our March 3, 2008, edition of Law Fax, we described new insurer reporting requirements that had been included in the Medicare, Medicaid, and SCHIP Extension Act of 2007 signed into law in late December, 2007. Under section 111 of the new Act, any "primary payor" will now have a duty to report any payment that it makes to a claimant, either by judgment or settlement, to the Department of Health and Human Services. That new section requires that any no-fault carrier, liability carrier, self-insured, third-party administrator or workers compensation carrier:

- determine whether Medicare has made any payment to or on behalf of the claimant, and if so,
- disclose the date and amount of any money paid to the claimant, and
- provide other information to be determined by the Centers for Medicare & Medicaid Services (CMS).

Under the statute, the new disclosure requirements are not to be effective until October 1, 2009. (CMS has asserted that July 1 is the implementation date, but will not in fact require reports until after September 2009.) Although the December, 2007 Act provided for only a one-year extension, this new requirement will undoubtedly continue in further extensions. Once an imposed obligation is adopted, it is very seldom withdrawn.

The purpose of this new disclosure requirement is to ensure that CMS has the information necessary to enforce its right of recovery. It is important to note that this new statute did not extend or modify CMS's rights of recovery under the MSP program in any way. It is simply a disclosure requirement.

The new statute imposes no obligation on the "responsible reporting entities" or RREs[2] to make a disclosure to CMS during the time that the case is pending. The obligation arises only after money has been paid. The reporting requirement applies regardless of the vehicle by which the resolution has been effectuated (judgment, settlement, arbitration) and regardless of whether the defendant has acknowledged or continues to deny liability.

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[2] The Federal government loves acronyms. We will simply use the term "insurer" in this article, recognizing that other entities will also have reporting responsibilities.

The determination as to whether Medicare has made any payment to the claimant is the same as it always has been. The insurer is on notice of Medicare's involvement if any of the following are true:

- The medical records reflect payments by Medicare
- The claimant is over age 65
- The claimant is receiving social security disability benefits
- The claimant suffers from end-stage kidney disease

Importantly, the reporting requirement will apply to payments made in all cases in which Medicare has paid any of the medical expenses. Even in cases in which Medicare does not have a right of recovery – such as a Michigan third-party liability case or uninsured motorist case, in which the plaintiff cannot under law recover medical expenses – the information will still need to be reported.

The fact that a case resolution is reported under this system does not mean that there is a right of recovery. It does mean that the payment is more likely than in the past to come to the attention of CMS and its contractors. And that is what was intended.

Implementation by CMS

CMS has now provided information to assist with the new reporting requirements, and to fill in the additional requirements as invited by section 111. This time, diverging from prior practice, it has not proposed new regulations. Instead, it has elected to announce the new requirements on its web site and has there provided detailed timelines and guidance as to how payors are to provide the required reports. It is providing this information now so that insurers can be ready to go when the new requirements go into effect after September 1, 2009.

A review of some of the information provided at the site shows that CMS's regulators do not have a good appreciation for the manner in which liability claims are asserted, proven, and paid. It makes reference to "claims for liability insurance" as if those benefits are to be applied for and processed like first-party no-fault benefits.

The web site for the new Mandatory Insurer Reporting (MIR) program is https://www.cms.hhs.gov/MandatoryInsRep/. It discloses the following timelines:

January 1 to July 31, 2009	CMS to develop its systems
May 1 to June 30, 2009	**reporting entities to register**
July 1 to September 30, 2009	testing period
October 1 to December 31, 2009	first reports to be submitted, according to a schedule to be announced

January 1, 2010	full and regularized reporting in place

The key points to note at this time are:

- Insurers will be directed to register on a "Coordination of Benefits Secure Web site", at a location to be announced at a later time.
- The information ("data elements") that are to be provided is set forth in an Attachment D, found at the MIR web site, and are extensive.
- It is expected that the web site will include an online form for entry of this information.
- The insurer is required to identify a person or persons with legal authority to bind it to the terms of the reporting requirements.

An interesting question is included on the form: "Was funding of the settlement, judgment, award or other payment contingent upon proof of resolution of Medicare's fee for service Medicare Secondary Payer recovery claim? Yes or No." This is a not-so-subtle hint that insurers should impose that requirement in connection with any settlement.

We would recommend that insurers (and others) monitor the MIR web site for updates and new information, and be prepared to register during the spring of 2009. We are, of course, available to assist our clients with any question or issue involving this program.