

# **Medicare, Medicaid and SCHIP Extension Act of 2007**

by James W. Bryan

## **I. Background**

- Senate Bill 2499
- Signed into law December 29, 2007
- Also known as the “MMSEA”
- Important part is Section 111

**[www.cms.hhs.gov/MandatoryInsRep/](http://www.cms.hhs.gov/MandatoryInsRep/)**

## **II. Section 111**

- A. Requires all liability insurers/workers comp insurers to report detailed information directly to Medicare each time a settlement, judgment, award or other payment is made to a claimant who is entitled to receive Medicare benefits.
  - 1. **Failure to comply with the reporting requirements carries a civil penalty of \$1,000 per claim/per day.**
  - 2. This will require insurance carriers to make substantial changes to the way they investigate and manage personal injury claims.

## **III. History of Medicare**

- A. Medicare Secondary Payer Act (MSPA)
  - 1. Established in 1980's, establishing Medicare as a secondary payer to other plans, such as auto liability/workers comp. (Non-GHP or Non Group Health Plans)
  - 2. Purpose was/is to allow Medicare to be reimbursed when a private insurance plan paid, or should have paid for a claimant's medical services.

- B. Medicare Prescription Drug, Improvement and Modernization Act of 2003. (MMA)
1. Strengthened Medicare's secondary payer status, clarifying that Medicare is ALWAYS a secondary payer.
  2. Made clear that Medicare can seek reimbursement from virtually any party who received a primary payment. (Including attorneys and private insurers).
  3. Medicare does not need to take into account issues of disputed liability or allocation.
  4. Medicare is not bound by the terms of settlement agreements purporting to determine who will have responsibility for repaying conditional payments to Medicare.
  5. Medicare, if not reimbursed, can initiate legal action to recover conditional payments. If they initiate legal action to recover those payments, they are entitled to recover double the amount of the payment(s) plus interest.

#### **IV. New Legislation**

- A. Medicare, Medicaid and SCHIP Extension Act of 2007 (Senate Bill 2499)
1. Goal is to secure Medicare's long-term financial viability by allowing it to more aggressively pursue recovery of conditional payments.
  2. Currently the reporting requirements are very vague:
    - a. Does not specify what information needs to be reported;
    - b. Does not specify how the information is to be reported;
    - c. Centers for Medicare and Medicaid Services (CMS), part of the Department of Health and Human Services, are tasked with developing the implementation of the MMSEA as part of their

oversight of the Medicare program. Details are still currently being released.

3. Information released so far regarding implementation:
  - a. Mandatory Insurer Reporting requirements for: Liability Insurers, Workers Compensation Insurers, Group-Health Plans and No-Fault Insurers;
  - b. Defined very broadly to include: Auto, UM, UIM, HO, Med Mal, PIP, Products and Med Pay coverages;
  - c. Duty to report is triggered whenever a RRE “determines a claimant is entitled to Medicare benefits” and a payment is made to or on behalf of a claimant;
  - d. The duty to determine whether a claimant is “entitled to Medicare benefits” falls solely on the RRE;
  - e. Data is reported to CMS’ Coordination of Benefits Contractor (COBC). RREs will register on-line through a secure website. Once an RRE’s registration application is submitted, the COBC will begin working with the RRE to set up the data reporting and response processes.
  - f. Not yet clear how the RRE is supposed to figure this out, but with \$1000/day/claim as the penalty for not reporting, you better be on top of it.
  
6. Medicare entitlement may exist for a WIDE variety of individuals including:
  - a. 65 and older receiving Social Security; eligible to receive railroad retirement; worked long enough to receive benefits from a govt. job; or a lawfully admitted non-citizen living in the U.S.A. for more than 5 years;
  - b. Younger than 65 but eligible because, received SSD for 24 months or longer; receives railroad disability; has Lou Gehrigs Disease;

worked long enough in govt. job; child or widower 50+ of a person who worked in govt. job long enough.

7. Insurance carriers are referred to as “Responsible Reporting Entities”. (“RRE”’s).
8. Ability to determine which claimants are subject to reporting:
  - a. Limited query access to Medicare eligibility records for purposes of enabling RREs to make determinations has not yet been granted;
  - b. Medicare weighing the need for the insurers to be able to gather the correct information against the privacy rights of Medicare beneficiaries;
  - c. May want claimants to sign a Social Security Release form (SSA-3288), so the RRE can submit to the local Social Security Admin. office for complete benefit eligibility information.
9. Need to continue to monitor claimant’s status:
  - a. Even if a claimant is not a Medicare beneficiary at the time the claim is opened, the reporting requirements will be triggered if the claimant subsequently becomes eligible for Medicare at any time before the claim is finally resolved;
  - b. Creates the obvious problem of a claimant who an insurer has an ongoing obligation to pay medical expenses. The insurer is then likely required to continually checking on the claimant’s medicare eligibility until the claimant turns 65 years of age.
10. No Safe Harbor for “Due Dilligence” by the Insurer: (as of now)
  - a. Puts an increased burden on the Insurer to make sure they are covering all bases involving the claimants potential as a medicare beneficiary;

- b. No magical “checklist” or form for the Insurer to fill out and show they’ve adequately investigated whether Medicare has an interest in the benefits. CMS does however claim to be developing such a form for future use;
- c. You should still be cautious and over-report rather than risk the hefty monetary penalties.

11. What data must be reported:

- a. Currently CMS has identified over 100 different data fields of specific information RREs will be required to gather and report;
- b. The nature and amount of the data fields will depend on the nature of the claim and the type of coverage in place;
- c. You’ll be required to report on things that have absolutely no bearing to adjusting the actual claim presented;

12. Some of the data fields include:

- a. SSN and Medicare Health Insurance Claim Number (HCIN) of the injured party;
- b. ICD-9 Diagnosis Codes that describe the injury and body part affected;
- c. Tax-ID number of the applicable insurance plan;
- d. The limits of liability;
- e. Specific information about claimant’s attorney, including the attorney’s Tax-ID number, firm name, address, etc.;
- f. Whether the insurer has an ongoing duty to pay benefits and when that ends;

- g. The amount paid out to the claimant.
- 13. Even when only a portion of a settlement or payment is for medical expenses, the entire sum paid out must be reported to CMS.
- 14. Reporting will be electronic ONLY. No paper will be permitted. RREs need to register and submit reports online by logging into a secure website which is currently under development.
- 15. When Does Mandatory Reporting Begin:
  - a. Liability Insurers/Work Comp Insurers need to electronically register between May 1, 2009 and June 30, 2009;
  - b. Each RRE will be assigned a technical rep from CMS to help establish appropriate protocols for the exchange of the electronic reporting information;
  - c. A testing period will take place from July 1, 2009 to September 30, 2009. On October 1, 2009, actual reporting for RREs will begin. ALTHOUGH, the effective date is still July 1, 2009, so the RREs will still need to be gathering the appropriate data from July 1, 2009 on, so that it can be reported after October 1, 2009.
- 16. How Often Does the Insurer Need to Report:
  - a. Only after a payment is made. So if it's a one-time liability settlement payment, you only need to report on that one-time basis. You are required to report on an "ongoing basis" for non-contested claims or claims involving multiple payments.
- 17. The MMSEA website:
  - a. [www.cms.hhs.gov/MandatoryInsRep/](http://www.cms.hhs.gov/MandatoryInsRep/)
  - b. Overview page will provide you with mostly the same information in this outline;

- c. There are separate tabs for GHP's and Non-GHP's;
- d. There's a "What's New" tab for recent updates;
- e. Also a section for Computer Based Training (CBT) opportunities for RREs and their agents;
- f. Also pages for transcripts of teleconferences on the new legislation and reporting requirements. Broken down into GHP and Non-GHP.

18. How will this affect Litigation:

- a. Administrative costs for the insurers of personal injury claims will significantly increase;
- b. Likely to create delays in settling cases while mandatory information is gathered;
- c. Could create a chilling effect in cases being settled, i.e., no duty to report until a payment is made;
- e. Nuisance settlements in cases with questionable liability will be affected the most.
- f. Settlement checks made out to both Plaintiff's Attorney Trust Account & Medicare?; Tentative settlement until Plaintiff provides proof that Medicare does not have a reimbursement interest?; Settlement checks made out directly to Medicare?