



## AGRC Claims & Risk Control Bulletin

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### *General Liability and Workers Compensation*

## **Medicare, Medicaid and SCIP Extension Act of 2007 [“MMSEA”] Imposes Strict Reporting Requirements on all Insurers and Self-Insureds to Report to CMS all Claimants who may be “Eligible” to Receive Medicare.**

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### **Brief Overview of Current MSP Statutes**

The Medicare Secondary Payer [“MSP”] statutes<sup>1</sup> have always posed a significant contingent liability exposure to self-insureds, insurance companies, third-party administrators, defendants, plaintiffs and plaintiff’s attorneys [“entities”]. However, most claims practitioners are unaware of the arcane statutory and regulatory requirements that have evolved around MSP recoveries and the potentially severe consequences imposed upon any entity if Medicare’s interests are not fully considered when resolving a claim where a Medicare payment has been made. Many claims practitioners still believe that all they have to do when settling such a claim is to obtain a release and hold harmless agreement from the plaintiff and leave the resolution of Medicare’s MSP to the plaintiff. Such a strategy can be very dangerous and costly. If the plaintiff does not resolve the MSP claim within 60 days, the MSP statute allows the government to “bring an action against *any or all entities* that are or were required” to reimburse Medicare as a “primary” payer<sup>2</sup>. Not only can Medicare potentially collect the entire amount of their payments, but they may also “collect double damages against any such entity.”<sup>3</sup> If the prospect of paying three times the amount of a claim that the claims practitioner thought was closed is not scary enough, the enforcement provisions in the statute allow “a private cause of action for damages...in the case of a primary plan which fails to provide for primary payments...”<sup>4</sup> The private cause of action also allows “double the amount” owed to Medicare as a bounty for the enterprising lawyer who brings such suits. The statute of limitations for such suits is six (6) years.<sup>5</sup> It is interesting to note that no private suits have yet been brought under the statute<sup>6</sup>. Nonetheless, the threat imbedded in the statute remains and

<sup>1</sup> 42 USC Sec 1395y(b) [Section 1862(b) of the Social Security Act]

<sup>2</sup> Section 1862(b)(2)(B)(iii). Because that statute allows the government to pursue “any entity”, it is highly probable that the government will seek recovery against the most financially viable party, leaving the self-insured, insurance carrier or other “entity” to pursue their contractual claims against individual claimants who may have little or no means to met their contractual obligations under the settlement agreement.

<sup>3</sup> Ibid

<sup>4</sup> Section 1862(b)(3)(A)

<sup>5</sup> 28 USC 2415(a)

<sup>6</sup> Under the MPS statutes, CMS has the right to pursue “any entity, including a beneficiary,...attorney... that has received any portion of a third party payment directly or indirectly...” Therefore, plaintiffs attorneys are included as “any entity” are also

should be a major concern to any entity that retains losses and is subject to the MSP statutes (who are most Fortune 1000 companies, their insurers and third-party administrators, including claimants and their attorneys).

With so many arrows in the government's MSP quiver, one has to wonder why Medicare has been so slow and ineffective in perfecting their claims against "primary payer" entities. While the explanations for Medicare's institutional inertia are many, it is clear that this may be changing quickly. With the graying of the baby boomers, record governmental deficits, a \$330 Billion budget that represents 3.2% of the gross domestic product that is projected to balloon to 11% of GNP by 2080<sup>7</sup>, the government will be keenly focused on seeking non-traditional funding sources (i.e. other than taxes) as a means of funding Medicare. The MSP is one of those sources. When viewed within this context, the passage of SB 2499 should serve as a wakeup call to risk managers and insurers that the government will be scrutinizing MSPs as a significant income stream. Claims practitioners and risk managers need to begin to develop strategic and tactical risk management techniques in order to respond properly to MSP claims, governmental audits, and governmental or private suits seeking MSP recoveries. Claims officers and risk managers need to prepare now to manage this loss exposure. Any claims practitioner, risk manager, or corporate claims officer who is not losing sleep over this issue is not paying attention to this emerging issue.

### **Medicare "Liens" under the MSP Statute and "Primary Payer" Entities' Primary Obligations to Pay**

It is important to understand the lexicon of the MSP statute in how it defines and considers the responsibilities of any party that pays or receives compensation for medical care that was paid by Medicare. Under the MSP statute, Medicare considers a "primary payer" to be anyone other than Medicare. Section 1862(b)(2)(A) defines "primary plan" as:

a group health plan or large group health plan,...a workman's compensation law... an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance,... An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance or otherwise) in whole or in part....

Therefore, in the Medicare world, all insurers, be it commercial general liability insurance, health care insurance or workers compensation insurance, all are treated the same. Medicare considers all insurance (including "self-insurance") to be "primary payers" and any payment that Medicare makes to a beneficiary or claimant is considered to be "conditional." The statute considers every person who may have a responsibility to pay a beneficiary's medical care as "primary." Therefore, Medicare's rights under the statute are not as a "lienholder" but rather as a party who, *by statute* is entitled to be reimbursed their "conditional payments." The MSP statutes do not recognize any differences between types of insurance. "No fault" types of insurance such

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subject to double damages under the statute [42 USC Sec 1395y(b)(2)(B)(ii). This may explain why the Plaintiffs Bar may be hesitant to file private suits allowed under the statute.

<sup>7</sup> "Medicare Reimbursement Problems", For the Defense, February, 2008 Annmarie Liermann, Jonathan Klein, Heather Kelly, James Meseck.

<sup>8</sup> Also known as the Medicare, Medicaid, and SCHIP Extension Act of 2007. While the Act contains many provisions germane to the payment of benefits and administration of other provisions of Medicare, it is Section 111 that addresses reporting requirements to CMS under the MSP that will have a profound impact on liability insurers, self-insureds, and workers compensation carriers.

<sup>9</sup> Section 1862(b) Social Security Act [42 U.S.C. 1395y(b)]

<sup>10</sup> Note the MSP statute uses the term "primary plan" rather than "Applicable Plans". The definitions are virtually identical save for the inclusion of "health care plans" in the "primary plan" definition.

<sup>11</sup> Ibid "In this paragraph, the term 'applicable plan' means that the following laws, plans, or other engagements, include the fiduciary or administrator for such law, plan, or arrangement: (i) Liability insurance (including self-insurance). (ii) No fault insurance. (iii) Workers compensation laws or plans."

<sup>12</sup> Note under current MSP reporting protocols, a claim cannot be reported directly to the Medicare Secondary Payer Recovery Center ["MSPRC"]. They must first be sent to the Medicare Coordinator of Benefits [or "COB"] in New York, who will then refer the claim to the MSPRC contractor in Detroit.

<sup>13</sup> We note the MPS statute does allow a private cause of action against Applicable Plans that also allows for two (2) times the amount of the uncollected conditional payments. (1862(b)(3)(A))

as health care plans, workers compensation, medical payments coverage, or no-fault auto are treated virtually the same as liability insurance that requires a finding of legal liability before the insurer's duty to pay damages is triggered. In Medicare's view, both are treated the same. The fact that the MSP statute treats all insurance the same (defined as "plans" or "alternate plans" under the statute) has created fundamental problems for both the Center of Medicare and Medicaid Services ("CMS"; the federal governmental agency responsible for administering Medicare) and primary payers in reimbursing Medicare. As defense attorneys, plaintiff's counsel, and other third party claims practitioners know, a defendant (be they self-insured or insured) has no duty to a third party claimant unless or until an arbiter in a civil trial or alternative dispute resolution forum has determined that such a duty is owed. The MSP statutes and CMS' regulations do not recognize that liability policies have no obligation to a third party, Medicare or anyone else unless the defendant "plan" "becomes legally obligated to pay damages ..." covered under the policy. Because liability policies also obligate the carrier to defend "plans" for covered claims, insurance carriers often dispense their defense duty by settling claims before their insureds are found "legally obligated" in a court of law. Such compromises are often based on the strength or weakness of the plaintiff's case against the defendant "plan" and the relative strength or weakness of the medical evidence that the claimant's injuries are in fact related to the acts or omissions of the defendant "plan." The MSP statutes do not take any of these issues into consideration when considering what a "plan" owes Medicare. The underlying assumptions in the MSP statute is that all "plans" are automatically "legally liable" for all claims made against them and that all injuries claimed by the plaintiff are related to the alleged injury causing event notwithstanding how hotly contested the issues. This fundamental disconnect between the MSP statutory framework, the operational reality of civil bodily injury jurisprudence, and "liability based" insurance policies makes the MSP statute dysfunctional.

Under the MSP statute, Medicare's right of reimbursement does not accrue until *after a third-party claim has been settled*. The beneficiary then has sixty (60) days to reimburse Medicare. If Medicare is not reimbursed with 60 days, the "plan" must also reimburse Medicare even though it may have already reimbursed the beneficiary/plaintiff. To complicate things still further, the Medicare Secondary Payer Recovery Center ("MSPRC"; CMS's third party administrator) is prohibited from "compromising" claims based on comparative fault. The net result of the current statutory protocols is that many claimants who have legitimate claims cannot find legal representation because plaintiffs attorneys do not want to accept the contingent liabilities any more than "primary payers" do; claim adjusters cannot settle claims with the MSPRC because there is no agreement on what is owed to Medicare; so claims go unresolved and Medicare does not collect their conditional payments.

The current dysfunctional MSP statutes and CMS regulations scream out for reform. Until CMS, the insurance industry, and the self insured community come together to fix these problems, primary payers will continue to face significant contingent liabilities and Medicare will not be able to collect their MSPs. While CMS recognizes they have been largely unsuccessful in collecting their "conditional payments", they have attributed this lack of success to the failure of "plans" to report claims rather than the statutory impediments we have just described. The recent passage of S 2499 in Congress should be ample evidence that CMS is serious about collecting MSPs and these issues are not going away anytime soon. While S 2499 adds significant draconian reporting requirements to the MSP statutes, they do nothing to resolve the basic problems primary payers and CMS face in reimbursing MSPs to Medicare.

### **S 2499 Adds New Teeth to the Current Dysfunctional System and Imposes Additional Contingent Liabilities for Non-Compliance**

Rather than focusing on the dysfunctional aspects of the MSP statutes and regulations that work at cross-purposes with Medicare's collection efforts, CMS have instead concluded that the lack of effective collections is primarily due to poor reporting. Senator Charles Grassley, R – Iowa, one of the foremost proponents of MSP reform and sponsors of S 2499 in his speech before the Senate on December 12, 2007 states:

...There are situations when Medicare is not the primary payer for a beneficiary's health care, but it is currently difficult to identify these situations. This legislation will improve the Secretary's ability to identify beneficiaries for whom Medicare is the secondary payer by requiring group health plans and liability insurers to submit data to the Secretary"

While S 2499 does not focus on the primary impediments to reimbursing Medicare's secondary payments, it instead creates stringent reporting requirements with severe penalties for non-compliance as well as a \$35 million budget to implement and enforce the reporting provisions.

The reporting requirements under S 2499<sup>8</sup> (that will become effective July 1, 2009) need to be viewed within the broader context of the Medicare Secondary Payer (MSP) statute<sup>9</sup> and the attempts by the CMS to collect "conditional payments" that by operation of the MSP statute, are the responsibility of "primary payers" or "plans." It is CMS's hope that the information and reporting requirements of the "Applicable Plans" (defined in the statutes as liability insurers, self-insureds, no fault insurers, and Workers' compensation, and TPA administrators<sup>10</sup>) will help them collect more MSPs. The focus of S 2499 is on establishing strict reporting requirements for "Applicable Plans." As Senator Grassley pointed out, the CMS has experienced difficulties in identifying applicable plans who may owe MSPs to Medicare. Included in S 2499 is \$35 million to enact the reporting provisions of the statute. While CMS has not yet released what specific information it will require of applicable plans, we anticipate that the focus will be on providing sufficient information to allow CMS to cross reference its existing databases to identify individuals and applicable plans who have not reimbursed CMS for their conditional payments. It is anticipated that this will be part of a broader effort by CMS to begin laying the groundwork for future enforcement activities of which the database will be an integral part. Therefore, insurance claim officers, risk managers, and third-party claim administrators and all applicable plans need to focus first on the specific requirements imposed on them by S 2499 within the broader context of the MSP statute.

### **Specific Reporting Requirements and Penalties Under S 2499**

Section 111 of S 2499 adds Paragraph 8 to 42 U.S.C. 1395y(b). Beginning July 1, 2008 it requires an applicable plan<sup>11</sup> to:

- Determine if a "claimant" is "entitled to benefits" under Medicare.
- If the "claimant" is entitled to benefits, then submit information on the claimant required by CMS to CMS.
- Submit the information on the claimant "in a form and manner (including frequency)" to CMS.
- Submit the information "within a time specified by [CMS] after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability)."

Any applicable plan that fails to comply with the reporting requirement "shall be subject to a civil money penalty of \$1,000 for each day of noncompliance with respect to each claimant." The \$1,000 per-day penalty for failure to report claims involving "eligible" claimants can have severe consequences for all applicable plans. A claim involving nothing more than an emergency room visit and "nuisance" settlement of a questionable liability claim resolved for several hundred dollars involving an "eligible" claimant (whither or not he or she actually received Medicare benefits) can easily evolve into a claim resulting in several hundreds of thousands of dollars! Therefore, it is extremely important that insurance carriers, self-insureds, and third-party administrators and all applicable plans implement investigation, documentation, and reporting protocols consistent with the S 2499. Non-compliance will be extremely costly!

Lastly, S 2499 also makes explicit that the late reporting penalties "are in addition" to existing penalties allowed under the statute for failure to take Medicare's interests into consideration. As reported earlier, this can include interests on the unpaid amount as well as up to two times the amount owed to Medicare.

### **Who is a "Claimant" Under S 2499?**

S 2499 defines "Claimant" as:

- (i) an individual filing a claim directly against the "applicable plan"; and
- (ii) an individual filing a claim against an individual or entity insured or covered by the "applicable plan."

Therefore, this would include anyone making a "claim" against a liability insurance carrier, self-insured (or

uninsured), any auto or no-fault auto insurance, any uninsured or underinsured auto policy, or workers' compensation claim. The statute does not require a suit to be filed, only that the individual has filed a "claim" for damages.

## **How Do You Determine Who "Is Eligible for Benefits" under S 2499 and Document Compliance?**

The statute places the burden on all "applicable plans" to determine if a claimant making a claim against them is also "eligible" to receive Medicare. The trigger is not that the claimant has actually received benefits under Medicare, but rather *are they "eligible" to receive benefits*. Review of the CMS website on the subject reveals that the following are individuals who may be eligible for Medicare:

- A person 65 years old.
- A person or their spouse who has Medicare-covered government employment.
- A person who is under 65 years old, but has received Social Security or Railroad Retirement Board disability benefits for at least 24 months.
- A person who is eligible to receive Social Security or Railroad benefits but hasn't yet filed for them.
- A person who has "End-Stage Renal Disease" and meets certain other requirements.

Other indicators of eligibility for Medicare are:

- Claimant has not worked for 30 months or more as a result of his injury-related disability.
- Claimant has a Medicare Health Insurance Card.

This list is by no means exhaustive and will need to be supplemented based on CMS' requirements when they establish eligibility protocols. However, applicable plans should not wait before beginning to develop standard questions or forms to be completed by claimants and/or their legal counsel as part of the standard investigations and claims best practices. All applicable plans will need to prove documented evidence of their compliance with S 2499. Applicable plan's RIMS systems (Risk and Insurance Management Systems) should be programmed to include captions that not only document the eligibility investigation required under S 2499, but also provide detailed reports as proof of compliance. Such information will be critical in preparing for anticipated governmental audits. Ongoing claims files audits (including Sarbanes/Oxley) and claim reviews should include focused attention on Medicare and S 2499 compliance.

## **Methods of Reporting to CMS under S 2499**

CMS has not yet established protocols for reporting claims under S 2499. While S 2499 requires information to be reported:

... within a time specified by [CMS] after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability), ...

Under existing guidelines, the MSPRC (the Medicare Secondary Payer Recovery Center; CMS's third-party contractor responsible for collecting MSP recoveries) does not recommend waiting until a claim is settled before reporting the claims to the COB<sup>12</sup> (Medicare Coordination of Benefits). This is because it takes a considerable period of time for the MSPRC to obtain documentation of Medicare's conditional payments. If a claims practitioner waits until the time of settlement to request this information from the MSPRC, there is a strong probability that they will not meet the 60 day deadline to reimburse Medicare after the settlement. This is because it may take over 60 days to obtain a list of Medicare's conditional payments. Therefore, we encourage "plans" to review their current MSP protocols to refine their current internal protocols to meet S 2499 mandates. We recognize that many (if not most) "plans" have not established protocols for MSPs. Traditionally, MSPs have been dealt with on an *ad hoc* basis, if at all. Claim practitioners have traditionally relied on the plaintiff's attorneys to deal with "liens" without being cognizant of the strict liabilities imposed by the MSP statutes and the contingent liabilities that can be imposed. While S 2499 only deals with reporting requirements, it is clear that the intent of the legislation is to provide strong incentives for applicable plans to develop such protocols. There will be severe consequences for those applicable plans who do not heed the

mandates established by S 2499 and start paying attention to the MSP statute.

S 2499 has not resolved the issue as to who should report the claim to CMS when there are multiple codefendants. If the claimant or their attorney reports the loss to CMS and identifies all of the codefendants will that be sufficient to constitute “notice” by all codefendants? Until this issue is resolved by CMS, we do not recommend ceding the reporting responsibility to anyone; be they codefendant or claimant. The consequences for non-compliance are severe and there are no safe harbors.

Lastly, what specific claimant information will need to be reported to CMS? This issue is also unresolved. There have been suggestions that applicable plans will need to provide such private information as social security numbers. This raises the potential of an identity theft loss exposure in the event that information technology security systems are breached. There is no indication that CMS will provide applicable plans with a safe harbor in the event that the information required to be collected somehow finds its way into the public domain. Because CMS will require that the reporting be done electronically, there is the potential that the applicable plan’s databases may become the target of cyber-thieves looking to steal the identity of individuals. Applicable plans are encouraged to discuss this potential loss exposure with their insurance brokers and IT security specialist to ensure proper safeguards are in place in the event of such attacks.

## Recommendations

In summary we recommend applicable plans consider the following:

- 1) Applicable plans (self-insured, insurance carrier, or TPA), if they have not done so, need to establish claims best practices for managing MSP claims. They should conduct training of all “claimant facing” adjusters who may have occasion to come across Medicare eligible claimants and be educated on current CMS MSP resolution protocols.
- 2) As part of the applicable plan’s MSP protocols, they should develop and implement “MSP eligibility questions” as part of their standard claim investigation. They should consider the development of a standard form to be given to every claimant (and/or their attorney if represented) that requests answers to these specific questions to determine the claimant’s “eligibility.” We recommend that this form become a part of every claim file. If the claimant refuses to complete such a form, then the claims practitioner should verbally ask these questions and document the claimant’s answers. We also recommend that all captioned reports include an MSP caption that addresses both claimant eligibility as well as documenting how Medicare’s interests were “considered.”
- 3) If the claimant is Medicare eligible, we recommend the claims be reported to the COB (Coordinator of Benefits, CMS’s administrative arm) as soon as possible, and be prepared to provide periodic updates to the MSPRC as required by CMS. The claims practitioner should also obtain a “Consent to Release” form. The MSPRC will not release any information (even to the claimant’s attorney) unless this form is completed. This should be done at the beginning of the claim. While S 2499 does not mandate reporting of claims until *after* settlement, we recommend that this be done early. To date, CMS has not established “frequency” guidelines for claims reporting. However, applicable plans should train their claims practitioner to know CMS’s reporting requirements and may want to consider enhancements to their RIMS system to provide either MSP diaries or automatic reports for submission to CMS in compliance with their guidelines.
- 4) While S 2499 requires “certain information” to be provided, CMS has not yet published what specific information will be required of Applicable Plans. When this information is published by CMS, we recommend that claims investigation protocols be reviewed and revised to be responsive to the acquisition and reporting of this information. Because the preliminary indications we are receiving indicate that CMS will require electronic reporting, applicable plans will need to review their RIMS capability, IT security protocols, and IT insurance coverage. RIMS systems should be configured to report claims electronically as required by CMS.
- 5) Lastly, we encourage all risk managers and insurance advisors to applicable plans to educate their senior management about MSPs and the potential impacts to their organizations. We encourage all stakeholders (insurance carriers, self-insureds, third-party administrators, and insurance advisors) to become actively involved in bringing about needed reforms that will ensure that MSPs are paid to Medicare efficiently while establishing reporting and claim resolution protocols that are fair to all. The

Medicare Action Recovery Coalition ["MARC"] is such a coalition. Please contact the author for more information on how you can become more involved.

There is little doubt that CMS's appetite to collecting "conditional payments" under the MSP statutes will only increase over time. The enactment of S 2499 provides CMS with additional tools to assert their claims against anyone who pays a claim to a person who is eligible to receive Medicare.<sup>13</sup> Those who do not recognize or prepare for these changes do so at their own peril. Just because the statutory regime governing the collection of MSPs is dysfunctional doesn't mean that an applicable plan can ignore the reporting requirements imposed by S 2499. In complying with S 2499, we must look to the more significant challenge of bringing about reforms to the MSP statutes that will allow CMS to collect the money they are due while creating a system that is both fair and easy to administer. We invite all stakeholders to join in this effort.

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