

## Medicare Reporting Rules Require Further Alterations

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This past March, important legislation was introduced in Congress that will change how Medicare Secondary Payer claims can be handled and managed. This exciting development has important implications for Medicare beneficiaries, corporations, insurers and third-party administrators.

In 1980, Congress adopted the MSP law to preserve the integrity of the Medicare Trust Fund. Medicare is now secondary to other forms of coverage for medical care.

In short, Medicare will pay first in some situations to limit inconvenience to the beneficiary, but will later seek reimbursement of these “conditional payments” from the responsible plans.

Section 111 of the Medicare & Medicaid SCHIP Extension Act of 2007—which set mandatory reporting requirements for workers’ comp and other medical insurers—generated a wave of awareness as well as confusion regarding MSP compliance.

Congress sought to improve awareness by the Center for Medicare and Medicaid Services, an agency of the U.S.

Department of Health and Human Services, of all settlements, judgments and awards in workers’ comp and liability matters. Therefore, it was mandated that insurance plans report to CMS payments made to a Medicare beneficiary.



The Medicare & Medicaid SCHIP Extension Act of 2007 created a new and significant enforcement tool for the federal government to pursue MSP claims, both by creating a new reporting process and shifting compliance responsibilities to the newly regulated community.

Plans must now identify Medicare beneficiary status and electronically report to the HHS secretary or face penalties of \$1,000 per day per claim, which could be devastating to the regulated community.

This transmission of information will be the first of its kind and establish complete awareness on the part of CMS, which will in turn use this knowledge to assert their recovery rights against beneficiaries, insurance carriers and self-insured entities—in most cases after the settlement.

CMS has and continues to adjust the reporting structure, currently scheduled to be in production as of 2011. Many entities are exchanging data to check Medicare beneficiary status in preparation for the production of claim-detail reporting.

The recent increase in MSP compliance has caused a great deal of confusion in the months leading up to electronic reporting under Section 111. CMS has now delayed implementation for electronic reporting three times, partly because of the confusion in the industry.

Claims administrators, insurance carriers and self-insureds are particularly vulnerable to these stops and starts, but it is clear that CMS is intent on implementing the law.

While it is appropriate for Medicare to be reimbursed by plans, the practical effect of the law will result in delays and increased litigation. To remedy this practical effect will require a change in the law—to create a process that will promote the public policy of settlement. That change and improvement begins with HR 4796—The Medicare Secondary Payor Enhancement Act of 2010 supported by the Medicare Advocacy Recovery Coalition.

MARC was formed in September 2008 to advocate for the improvement of the MSP program for beneficiaries and affected companies. Formed by a group of entities in the regulated community, the coalition has been collaborating and developing strategic alliances with congressional leaders and government agencies to focus on broader MSP reform.

MARC's membership is comprised of entities representing virtually every sector of the MSP-regulated community—including attorneys, brokers, insureds, insurance carriers and trade associations, self-insureds, and third-party administrators. Presently, MARC has over 60 active organizations.

H.R. 4796 was introduced by Rep. Patrick Murphy, D-Pa., and co-sponsored by Rep. Tim Murphy, R-Pa., in March 2010. The bill speeds the Medicare Trust Fund's recovery of Medicare expenses while streamlining the payment process and providing certainty and finality to all parties to a claim.

When enacted, the Medicare Secondary Payer Enhancement Act of 2010 would:

- **Revise the information flow** so that the Medicare Secondary Payer can be determined, and paid, before settlement.

The bill would create an avenue for parties involved in a case to either obtain the conditional payment amount, or allow beneficiaries and others, based upon a good faith estimate from billing records, to calculate and make the reimbursement payment to the Medicare Trust Fund directly.

Finality is achieved by establishing a time period for CMS to respond, or the payment becomes the final MSP amount and the MSP obligation is completed. CMS can dispute the payment amount and pursue resolution through an administrative appeals process.

- **Establish the right of appeal.** The bill would give non-group health plans the same right of appeal through an administrative law judge and the federal court system as group health plans enjoy today.
- **Set MSP recovery thresholds.** To eliminate the waste and expense associated with small-dollar MSP recoveries, the bill would create a \$5,000 threshold, measured by the settlement or other payment, below which parties are exempt from all MSP obligations.
- **Take out of the reporting process** Social Security numbers and health insurance card numbers. To protect beneficiaries and their privacy rights, the legislation will give CMS one year to adopt a system of reporting without requiring responsible reporting entities to obtain these sensitive numbers from a beneficiary.
- **Set a limitations period** for MSP claims. The MSPEA will clarify that the government has a three-year period to assert its claim from the date of a Section 111 report.
- **Revise reporting penalties.** The bill will correct the current Section 111 penalty provisions to provide the government with enforcement discretion and ensure proportional penalties, and require the Department of Health and Human Services to develop safe harbors for meeting reporting requirements.
- **Establish a user fee** to offset the cost of the legislation of \$30 per claim if the optional expedited voluntary payment or pre-settlement request for a final demand of conditional payment option are utilized.

For more information about this bill, please visit [www.marccoalition.com](http://www.marccoalition.com).

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