

## Complying with the Medicare Secondary Payer Law – Update

Congress passed the Medicare & Medicaid Schip Extension Act of 2007 (MMSEA) to require electronic reporting of workers' compensation, no-fault and liability claims to Medicare. Those claims that involve a settlement, judgment, award or other payment to a Medicare beneficiary claimant were to be reported starting January 1, 2011. Three years after the law took effect, the reporting deadline was recently changed for certain lines of business. Data challenges to process information required the Centers for Medicare & Medicaid Services (CMS) to modify the timeline. A collective sigh of relief was felt by the industry, but yet at the same time a feeling of uncertainty loomed on the horizon. What now is compliance with the Medicare Secondary Payer Act?

The Medicare Secondary Payer Act (MSPA)<sup>1</sup> is a game changer for anyone involved in the resolution of a claim with a Medicare beneficiary claimant. When the MSPA was amended by the MMSEA to include the new electronic reporting provision the metamorphosis of the law was complete and certainly caught the industry by surprise. Initial reaction by most focused on penalties surrounding the new reporting requirements; but it soon became evident to some that with the volume of data to be sent to Medicare, other aspects of the MSPA would create contingent liability if not properly addressed. Compliance therefore became more than being certain the data submission to Medicare was right, but comprehensive enough to include conditional payments owed Medicare be repaid and Medicare's interests protected.

There are three parts to complete MSPA compliance. Once the law is triggered, each piece must be independently analyzed and if all aspects of it are not properly addressed, there is exposure to MSPA liability. A comprehensive approach is necessary to manage all of these elements.

### *When is responsibility under the MSPA triggered?*

When a Medicare beneficiary claimant settles, receives a judgment or award; or another payment is made related to a workers' compensation, liability or no-fault claim, MSPA responsibility is triggered. The MSPA does not apply unless a Medicare beneficiary is involved. Moreover, if there is no payment obligation owed the Medicare beneficiary that has the effect of paying for or releasing medicals no MSPA responsibility can exist either. Two parts are required – Medicare beneficiary claimant *and* an obligation to pay a Medicare beneficiary claimant for medicals.

Another aspect to consider is claim type. MSPA became law on December 5, 1980 and added liability and no-fault claims where Medicare would pay for medical items and services related to a claim as a secondary payer. Medicare was a secondary payer for workers' compensation claims since Medicare became law on July 1, 1965. Therefore there is a distinction between workers' compensation and other claims. MSPA responsibility for liability and no-fault claims starts for those claims with an accident date on or after December 5, 1980. Workers' compensation claims MSPA responsibility relates back to when Medicare became law or July 1, 1965.

Although the date of accident is determinative of claims that come under the MSPA, when the claimant becomes a Medicare beneficiary is also important. Medicare beneficiary status at the time of the accident is not relevant. Rather it is the claimant's status at the time the

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<sup>1</sup> See 42 USC §1395y(b)

obligation is created to pay the settlement, award, judgment or other payment that defines the trigger.

### The Three Parts of MSPA Compliance

Primary plans are insurance carriers and those that self insure their risk for workers' compensation, liability and no-fault claims involving a Medicare beneficiary claimant. Their status as a primary plan occurs when the MSPA is triggered. As a primary plan they face three MSPA obligations. They are: conditional payment reimbursement; reporting to Medicare; and protecting Medicare's interests. It is easier to understand it as a past, present and future responsibility owed Medicare.

#### *Past Obligations Owed to Medicare*

If Medicare pays, it does so on the expectation that it be reimbursed for those medical items and services related to the claim. See 42 U.S.C. §1395y(b)(2)(B)(ii) and (iv). Payments made by Medicare in these situations are called conditional payments. Responsibility to repay Medicare occurs sixty days after a final demand is made by Medicare. As the final demand from Medicare occurs subsequent to a settlement, award, judgment or other payment, a primary plan is exposed. Under 42 C.F.R. §411.24(i) the primary plan is responsible to pay Medicare, even if payment has already been made to the Medicare beneficiary. Compliance here requires a proactive approach with the Medicare beneficiary *before* the obligation to pay is incurred to avoid contingent exposure to Medicare.

Should the Medicare beneficiary not complete this obligation, Medicare will refer the conditional payment debt to the Department of Treasury for collection. At this point, the matter is now a debt under the Federal Claims Collection Act and the Treasury department is authorized to levy any funds in its possession to satisfy this debt. Anyone that has received payment from the primary plan, and the primary plan itself, are potential targets. However, because of its deep pockets, the primary plan is likely to be the choice for the Government to pursue in its efforts to be made whole. In the past it was difficult for Medicare to identify the primary plan, but once Section 111 reporting is a reality, that roadblock will no longer exist.

Initial reaction to this potential problem by primary plans was to add Medicare as a payee on a settlement check or require Medicare beneficiary's counsel to personally indemnify the primary plan. These so-called solutions do not work. First, this process cannot be applied to awards and judgments. See *Zaleppa v. Seiwel*, 2010 PA Super 208 (11/17/2010). Thus, it is not a complete solution. Furthermore, adding Medicare as a payee only works if the Medicare beneficiary agrees to it. Primary plans cannot accomplish this unilaterally. See *Tomlinson v. Landers*, 2009 U.S. Dist. LEXIS 38683. Finally, requiring indemnification from a Medicare beneficiary's attorney presents ethical challenges in most jurisdictions.

The most logical approach to MSPA compliance for past obligations owed Medicare is for the primary plan and Medicare beneficiary to cooperate. Medicare will not present a demand until after a case is resolved. This aspect of the MSPA is a challenge, because Medicare does not compromise on its demand and has the authority to take the entire amount if the resolution is less than what it is owed. See *U.S. v. Hadden* 2009 U.S. Dist. LEXIS 69383. However, the parties can obtain an estimate from Medicare. While not perfect, it is a better guideline than no information at all. Furthermore, once the approximate number is known, the parties can also agree on how it will be satisfied *before* the claim is resolved.

## *Present Obligations Owed to Medicare*

This aspect of MSPA compliance can be most confusing in light of the recent announcements by CMS. However, the general rule today is when a primary plan incurs an obligation to pay a Medicare beneficiary claimant; it also becomes responsible, at the same time, to report it to Medicare. The confusion exists because a primary plan is subject to two separate and distinct reporting obligations under the MSPA - 42 CFR §411.25 and MMSEA or 42 U.S.C. §1395y(b)(8) or better known as Section 111.

### 42 CFR §411.25

Under 42 CFR §411.25, the primary plan is 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. This has been law for over twenty years, but no one has known about it, let alone complied with it.

Once Medicare is aware of a claim on its own or through other means it will react.<sup>2</sup> First it will deny payment of any pending claims on behalf of the Beneficiary for a period of 120 days while it investigates if other insurance or self insurance is responsible. Second, it will identify any payments it may have made related to the claim and demand reimbursement.

Compliance with this aspect of the MSPA requires reporting today. It does not have anything to do with Section 111 electronic reporting and is a legal obligation that has existed since 1989. There is no penalty for non-compliance, but Medicare has processes in place to become self-aware of the claim. When it does, the primary plan has long resolved the claim and may be the only entity with deep pockets to pay Medicare. To avoid this potential MSPA liability requires attention to Medicare obligations *before* a claim is resolved and not after.

### Section 111 Reporting

When Section 111 reporting takes effect, certain primary plans will be required to report claims data to Medicare. These reporting primary plans are called Responsible Reporting Entities (RRE). Whether or not a primary plan is also an RRE depends on CMS guidelines.<sup>3</sup> In general, the insurance company is the RRE and its insured is not. The size of the deductible or whether the insured has control over claims administration is of no consequence in that determination.

CMS redefined the RRE around policies of insurance in an effort to limit the number of reporting entities. Originally, insureds were allowed to register as the RRE in situations where it paid its deductible directly to the Medicare beneficiary. This made sense, as CMS considered a deductible an equivalent to self insurance. However, data processing challenges created by the unexpected large number of RREs being registered caused CMS to

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<sup>2</sup> The Coordination of Benefits Contractor (COBC) has launched the MSP Claims Investigation Project. The COBC trains health care providers to bill suspected primary plans first *before* Medicare. Once the health care provider is denied the health care provider can submit bills for payment by Medicare as a secondary payer. During this process COBC identifies potential sources to seek recovery.

<sup>3</sup> MMSEA Users Guide, ver. 3.1

change to the present policy. Section 111 penalties apply only to RREs, but primary plans that are not RREs still have MSPA responsibility. That being said, it is important for primary plans to make certain Section 111 compliance is achieved.

A challenge for RREs compliance is the new reporting timelines issued by CMS. Workers' Compensation, No-Fault and other claims involving ongoing responsibility for medical will be reported, as scheduled, starting January 1, 2011. However, liability claims reporting will be delayed.

#### *Workers' Compensation and No-Fault Section 111 Reporting*

There are two types of reporting – settlements, awards and judgments releasing medicals; or claims involving medical that are not pending resolution. The former has been defined by CMS as Total Payment Obligation to Claimants (TPOC); while the latter is defined as Ongoing Responsibility for Medical (ORM).

A TPOC situation is created when there is a settlement, award or judgment releasing medicals. If the obligation took place on or after October 1, 2010, the RRE is obligated to report that situation electronically to Medicare in the following quarter.

The ORM reporting situation is more of a challenge. The RRE is required to identify all open claims as of January 1, 2010, involving a Medicare beneficiary where it has responsibility for medical. Thereafter, any new or re-opened claims must be analyzed for this responsibility and where appropriate identified for reporting. Finally, any open claim previously not identified as involving a Medicare beneficiary needs to be monitored ongoing for Medicare beneficiary status. If there is any change in status, that claim is also subject to reporting. The date of the accident is irrelevant for workers' compensation, however, for no-fault claims, no accidents before December 5, 1980 are subject to the analysis. The collected information is then reported next year, and once every quarter thereafter.

No matter what the line of business, if the RRE assumes responsibility for medical expenses then it must report that responsibility under Section 111. There is no data field for the "start date" as it is assumed to be the date of the accident. Medicare makes this presumption to increase its reimbursement claim. During the period that the RRE assumes ORM, Medicare will not pay for medical items and services related to the claim and if it did or does, it will want to be paid back. Medicare will only reassume responsibility as a primary payer when the RRE reports that its ORM has ended and includes a date.

ORM reporting will result in compliance challenges for workers' compensation primary plans. Typically, workers' compensation primary plans do not involve Medicare unless there is a potential that a claim be resolved. In those situations, the claims professionals usually deal with Medicare on a prospective basis to protect Medicare's interest with regard to future medical. However, ORM reported data will now identify conditional payments and moreover it will be on those claims that are not being resolved. The primary plan will need to adjust its process to handle Medicare issues on workers' compensation claims that remain pending.

Conditional Payment Notices must be responded to within thirty (30) days. The RRE has no right of appeal, but should be able to contest relatedness, if it acts quickly. If not, this will be a huge cost driver for the worker's compensation line of business that may be saddled with payments that may not be covered under the state compensation system. The workers' compensation primary plan will need to be prepared for it. Workers' compensation examiners will need to be familiar with these new notices as the notices will need to be

responded to within the allotted time or it will be assigned to the U.S. Department of Treasury for collections.

#### *Liability Claims Section 111 Reporting*

Liability TPOC claims reporting is delayed. RREs are required to collect TPOC situations that occur on or after October 1, 2011 for reporting the following quarter. All settlements, judgments and awards that involve a Medicare beneficiary before then may be reported, but such reporting is voluntary. There are no Section 111 penalties associated with voluntary reporting.

Liability ORM situations are not part of the announced delay by CMS. ORM is to be reported beginning January 1, 2011, as previously scheduled. RREs that have medical payments coverage will be impacted. MSPA compliance required primary plans to evaluate all open claims as of January 1, 2010 and identify those situations where it was responsible to pay medical involving a Medicare beneficiary. Thereafter, any new claims are similarly analyzed as well as those that are re-opened. Claims that are open, but previously not identified as involving a Medicare beneficiary, must have processes in place to monitor a change in claimant's status to a Medicare beneficiary. Section 111 penalties will apply to a primary plan that fails to report liability claims involving ORM.

#### *Section 111 Reporting TPOC Thresholds*

Certain TPOC claims are exempted from Section 111 reporting. Because CMS modified Section 111 timelines, it also extended the threshold periods as well. TPOC amounts that are \$5,000 or less are exempt from reporting for obligations incurred before December 31, 2012. For 2013, the TPOC amount threshold is reduced to \$2,500 and further reduced to \$600 in 2014. Starting in 2015 there are no TPOC amount reporting thresholds. Primary plans that resolve a claim with a Medicare beneficiary for a penny will be required to comply with Section 111 reporting.

RREs are in compliance with Section 111 registration if: 1) the required registration process is complete, including submission of a signed profile; or 2) the RRE has notified the COBC of its inability to register during the initial designated time frame; and 3) the RRE 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).

#### *Future Obligations Owed Medicare*

Medicare is owed a future obligation where medicals are being released prospectively. There is an expectation by Medicare that payment will be made by the primary plan under 42 U.S.C. §1395y(b)(2)(A)(ii). Medicare does not want to have responsibility for health care shifted to it when another entity is responsible for such care and treatment. The purpose of the MSPA is to protect Medicare when the primary plan is responsible for paying such medical benefits. Protecting Medicare's interest is avoiding this shift. *See 42 CFR §411.46.*

#### *CMS created a recommended process for workers' compensation primary plans*

Compliance of this future obligation owed Medicare is clearer for the workers' compensation claim. The Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is the accepted method by the industry. Although it is a "recommended" process, there is a threat

that a settlement could be invalidated unless previously approved by CMS. Thus, the WCMSA is an accepted method to avoid contingent liability.

The recommended rules for the workers' compensation claim can be found at CMS website.<sup>4</sup> These guidelines recommend a WCMSA be reviewed by CMS in two situations. If the settlement is for \$25,000 or more and involves a Medicare beneficiary, then the WCMSA must be reviewed and approved by CMS. Where the settlement does not involve a Medicare beneficiary, but the claimant is expected to be a Medicare beneficiary within 30 months of the settlement; then those matters involving \$250,000 or more must be reviewed and approved by CMS. For these situations, the primary plan is relieved of contingent liability for this future obligation.

For all other workers' compensation settlements, compliance is unclear. The guidelines issued by CMS for approval were designed based on budget and workload restrictions for CMS staff. However, these limitations are not a safe harbor for the workers' compensation primary plan. Medicare has the authority to invalidate any settlement where the future obligation is not properly resolved at the time of settlement. In many respects these cases are subject to the same confusion that is presented for all liability settlements.

#### *No Recommended Process Exists For Liability Claims*

There is a great deal of debate about whether parties to a liability settlement must deal with the future obligation owed Medicare. It is absolutely true that there are no regulations or guidelines that set forth the obligation, but that is not determinative of the obligation. Whether it exists must come from the MSPA itself; and after careful consideration of the issue, it is difficult to ignore that Medicare interests must be considered.

Two parts of the MSPA requires this conclusion. First, Medicare is not obligated to make payment to a Medicare beneficiary where "payment has been made, or can reasonably be expected to be made" by a primary plan. See *42 U.S.C. §1395y(b)(2)(A)(ii)*. Second, a primary plan is responsible to reimburse Medicare where it is demonstrated it "has or had a responsibility to make payment for such item or service." A primary plan's responsibility is "demonstrated" by a release "for items or services included in a claim against the primary plan or the primary plan's insured". See *42 U.S.C. §1395y(b)(2)(B)(ii)*.

Thus, when a liability case involves a release for future medical, how does it not trigger MSPA responsibility? Medicare would expect payment based upon the primary plan's responsibility demonstrated by the release; and if it pays for medical items and services then Medicare will expect reimbursement. Most that debate against this conclusion cite the Medicare Secondary Payer Manual in support. "There should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement." See *CMS Medicare Secondary Payer Manual, Chapter 7, §50.5*. But that statement cannot be reconciled with the sentence that follows it in the manual. "However, the entire amount of a settlement is subject to recovery, whether the liability payment is made at the time of settlement, or over a period of time agreed to by the parties in a structured settlement." The implication is obvious that the entire settlement amount is subject to Medicare recovery, and if the primary plan does not protect itself, it will be subject to MSPA contingent liability.

How then is compliance achieved in the liability case? It is probably easier to define it by what not to do. Doing nothing to satisfy Medicare's interests is probably unwise. In a recent CMS conference call that was made clear when it was stated in response to a

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<sup>4</sup> [https://146.123.140.205/WorkersCompAgencyServices/04\\_wcsetaside.asp](https://146.123.140.205/WorkersCompAgencyServices/04_wcsetaside.asp)

question on Medicare Set-aside Arrangements in liability cases: "There is not - the same formal process for liability set asides that there is for Worker's Compensation. However the underlying statutory obligation is the same."<sup>5</sup> Something must be done to properly address this issue. But how can this dilemma that faces the primary plan be resolved?

Consider a cooperative solution with the other party to the litigation. Is future medical really involved in the settlement? If not, properly document it in the release. However, where there is future medical involved, the parties should protect a portion of the settlement proceeds on behalf of Medicare. There are many ways to approach how to do this, but it makes sense something be done that protects the parties.

If cooperation cannot be achieved, then the primary plan needs to mitigate its contingent liability. The MSPA is a prohibitory statute because it stops Medicare from making a payment where a primary plan is responsible. Thus, it stands to reason the Medicare beneficiary will be the first to feel the impact. If Medicare should suspend benefits because of the settlement, the beneficiary will contact the primary plan. Normally, the primary plan can rely on its release, but the MSPA creates a private cause of action for the Medicare beneficiary that allows the collection of double damages against the primary plan. Whether the Medicare beneficiary will be successful in prosecuting that claim is unknown, but the costs of defense could be prohibitive. Consequently, the primary plan should consider waiving that private cause of action (42 U.S.C. §1395y(b)(3)(A)) as part of the release which should be supported by adequate consideration.

## Conclusion

Compliance with the MSPA will not be easy. It is a law that is thirty years in the making and presents to the primary plan contingent liability over past, present and future obligations owed Medicare. Specifics of compliance are not clear, but the primary plan can reduce its exposure if it understands how the obligations work.

The obligation that has most occupied the industry's attention is preparation for reporting information about claims to Medicare. Recent changes by CMS on primary plan's reporting responsibilities has presented some relief, but at the same time, what will occur around workers' compensation and no-fault claim information reporting remains uncertain. Nonetheless, it has caused the industry to work on improving its MSPA awareness and as with anything new, it will take a period of time for the process to settle down. To avoid contingent liability, the primary plan must cooperate with all sides involved in the claim. Short of this, not many options exist, as the MSPA is designed to make Medicare whole. The Act creates the authority for Medicare to seek reimbursement from anyone connected with the claim; and as a consequence of the primary plan's deep pockets, the plan is probably the most desirable target. The MSPA is justifiable in that the primary plan, after it has reimbursed Medicare, has the right to seek recovery from the Medicare beneficiary or any other entity that it has previously paid money to connected with the loss.

All aspects of the MSPA must be considered – past, present and future obligations that are owed Medicare. Compliance is complete when each are satisfied. The obligation is owed, and the primary plan cannot effectively transfer its MSPA risk by terms of the release agreement. Finality is only achieved if the obligations are managed before the resolution of the claim. Anything short of early intervention and cooperation increases the risk that contingent liability could turn into a reimbursement claim sixty days after the Medicare final demand is issued.

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<sup>5</sup> [CMS Town Hall Transcript, 09/30/2009 at page 25.](#)

MSPA is a new reality for primary plans. Although it has existed for over 30 years, only recent reporting amendments have caught the attention of the industry. Now that the primary plans will present data to Medicare, it is important that the information not be used to create additional liability beyond the claim settlement. Primary plans should review its MSPA compliance protocols to effectively manage the processes articulated in this article.