Insurers' New Reporting Obligations Under Medicare Medicaid SCHIP Extension Act
Complying with MMSEA Requirements for Payors of General Liability and Personal Injury Claims

A Live 90-Minute Teleconference/Webinar with Interactive Q&A

Today's panel features:
W. Randall Bassett, Partner, King & Spalding, Atlanta
Christy A. Tinnes, Principal, Groom Law Group, Washington, D.C.

Wednesday, March 3, 2010
The conference begins at:
1 pm Eastern
12 pm Central
11 am Mountain
10 am Pacific

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Group Health Plan
Insurer Reporting Obligations
Under MMSEA

Christy Tinnes
Groom Law Group
March 3, 2010
Overview

- General Medicare Secondary Payer and MMSEA Rules
- Group Health Program Rules
  - For Health Insurance/Health Plans
- Non-Group Health Program Rules
  - For Liability Insurance, No-Fault Insurance, and Workers' Compensation
KEY

- CMS = Centers for Medicare and Medicaid Services
- GHP = Group Health Plan
- HICN = Medicare Health Insurance Claims Number
- MSP = Medicare Secondary Payer
- NGHP = Non-Group Health Plan
- RRE = Responsible Reporting Entity
- SSN = Social Security Number
What is MMSEA?

- Medicare, Medicaid & SCHIP Extension Act of 2007 (MMSEA)
- 42 USC 1395y(b)(7) – Applies to Health Insurance
- 42 USC 1395y(b)(8) – Applies to Liability Insurance, No-Fault Insurance, and Workers' Compensation
- Penalty for Noncompliance - $1,000 for each day of noncompliance for each individual for whom a report should have been submitted

- [www.cms.hhs.gov/MandatoryInsRep](http://www.cms.hhs.gov/MandatoryInsRep)
**MMSEA applies in two steps:**

<table>
<thead>
<tr>
<th>Step 1:</th>
<th>Step 2:</th>
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<tbody>
<tr>
<td>- Group Health Plans (GHPs) / Health Insurers</td>
<td>- Non-Group Health Plans (NGHPs) / Liability, No-Fault, and Workers' Compensation Insurance</td>
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<td>- CMS wants to know which health plan participants are eligible for Medicare to verify whether MSP rules have been applied correctly.</td>
<td>- If Medicare paid primary (under GHP step) and individual recovers from another source (lawsuit, Workers' Comp), CMS may want to recover a portion.</td>
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<td>- Will use to determine which party should pay first – health plan or Medicare.</td>
<td>- NGHP must report recoveries.</td>
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<td>- GHP must report Medicare-eligible beneficiaries.</td>
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General MSP Rules
(But can have lots of nuances)

- Individuals can be eligible for Medicare due to Age (at 65), Disability, or End Stage Renal Disease.
  - Age – Medicare pays primary for retirees age 65 and over. Health plan pays primary for active workers age 65 and over (working aged).
  - Disability – Health plan pays primary for employers with 100 or more employees. Medicare pay primary for employers with less than 100 employees.
  - End Stage Renal Disease – Health plan pays primary for first 30 months, then shifts to Medicare.
  - Special rules for small employers with less than 100 employees.
GHPs – General Rule

- As of January 1, 2009, GHPs must identify and submit situations where the GHP is or has been a primary plan to Medicare.

- RREs for GHPs must report information about Medicare-eligible plan participants to CMS.

- CMS will use this data to verify which party (Medicare or the group health plan) should be paying primary.

- Replaces current voluntary data match program.
GHP Rules
Which party must report?

- RRE is an entity serving as an insurer or third party administrator for a group health plan.
- If health plan is self-insured and self-administered, a plan administrator or fiduciary is the RRE.
- Employers sponsoring health plans generally not required to report (unless self-administer plan).
- Generally, TPA or insurer will look to employer for some information, such as SSNs, but TPA or insurer will file the report.
GHP Rules
Small Employer Exception

- If an employer has fewer than 20 employees (full or part-time) and contributes to a single employer plan, they do not have to comply.

- Number based on number of employees, not number of plan enrollees.

- However, if employer participates in a multiple employer or multi-employer plan and at least one participating employer has at least 20 employees, then they must report.
GHP Rules
Who must be included on report?

- Reporting only required for Medicare-eligible individuals.
- Reporting required for employees AND dependents.
- Plan can either:
  - Have individuals certify whether they are Medicare eligible or not (CMS has provided sample certification).
  - Query Medicare on specific individual's entitlement.
  - Report safe harbor group of "Active Covered Individuals" (see next slide).
GHP Rules
Who must be included on report?

- Safe harbor if plan reports certain "Active Covered Individuals":
  - All individuals age 55 to 64 (as of 1/1/11, this changes to ages 45 to 64).
  - All individuals age 65 and older.
  - All individuals under age 55 whom the RRE knows are Medicare beneficiaries (as of 1/1/11, this changes to age 45).
  - All individuals who are receiving kidney dialysis or have received a kidney transplant (regardless of age).
GHP Rules

What information must be reported?

- Quarterly electronic filing based on date provided by CMS.

- Report must include:
  - Employer Tax ID Number (TIN) or Employer ID Number (EIN)
  - Number of employees versus number of enrollees
  - SSNs or HICNs for Medicare-eligible individuals
GHP Rules
Common Issue: SSNs

- Some individuals reluctant to provide SSNs (and employer not likely to have SSNs for dependents).

- CMS has issued an alert that explains need for SSN that employer can provide to individuals.

- Some employers requiring SSNs as part of Open Enrollment and not allowing coverage if individual will not provide SSN.

- CMS says collection of SSNs for MMSEA reporting is permitted under state law.
GHP Rules

Resources

- MMSEA Section 111 MSP Mandatory Reporting GHP User Guide.

- CMS has held a number of Town Hall Teleconferences allowing interested parties to call in with questions. Transcriptions and audio files available on CMS website.

- Next call: March 18, 2010 from 1 -3 EST.

- [www.cms.hhs.gov/MandatoryInsRep](http://www.cms.hhs.gov/MandatoryInsRep)
GHP Reporting – Questions?
Reporting and Liability Issues for Liability and No-Fault Insurers and Self-Insured Entities Under MMSEA and MSP

W. Randall Bassett
King & Spalding
March 3, 2010
Costs and Benefits of MMSEA

- **400 hours**: estimated minimum cost of designing, building, and operating a system to comply with MMSEA
  - *does not include ongoing costs*

- **$200 million**: estimated amount Medicare expects to shift back to “primary plans”
  - *as expanded to include self-insured entities*

- **$89 trillion**: estimated amount of Medicare’s unfunded liabilities
  - *5X greater than Social Security’s unfunded liability*
Medicare Legislation
Medicare Secondary Payer (MSP)

- Medicare secondary payer (MSP) provisions enacted in 1980s
- Medicare generally will not pay for treatment if any another entity has an obligation to pay
  - The responsible entity is known as the “primary plan”
- Medicare authorized to recover payments from a primary plan even if the primary plan has already paid to settle the claim
The Medicare Prescription Drug Improvement, and Modernization Act of 2003 ("MMA")

- Expanded the definition of “primary plan” to include “self-insured” entities that bear their own risk
- Includes tort defendants who pay judgments and settlements out of their own pockets (self-insured entities)
The Medicaid, Medicare, and SCHIP Extension Act of 2007 (MMSEA)

- CMS no longer has a mere right to seek reimbursement
- Imposes an affirmative duty on entities including tort defendants to report the resolution of any claim or action brought by a beneficiary
- Provides stiff penalties for failure to report – up to $1,000 a day per claimant
Implementation of MMSEA Section 111

- CMS is responsible for implementing the very complicated provisions of the Medicare statute--how?
  - Guidance issued – User’s Guide
  - Alerts supersede User’s Guide
  - Regulations adopted through notice and comment rulemaking
Medicare Right to Reimbursement

- A tort defendant’s responsibility is established through judgment, settlement, or other payment to Medicare beneficiary
- No admission of liability is required
- Scope of release and scope of medicals claimed is irrelevant to reporting obligation
- CMS may recover from beneficiaries and third parties who receive funds from primary plans
- If CMS is unable to recover from the recipients it may seek payment directly from the primary plan even if it has already paid to settle the claim
Relationship Between MMSEA and MSP

- MMSEA establishes reporting requirements and fines for failing to comply. It does not grant Medicare an independent right of reimbursement.

- MMSEA is intended to give CMS additional information about payments to Medicare beneficiaries to ensure that Medicare only pays for services for which it is liable.

- Based on the information received pursuant to MMSEA, Medicare can then assert its rights under the MSP to recover conditional payments for which other parties -- including tort defendants -- are primarily liable.
RREs face potential liability to Medicare from multiple avenues:

- failure to properly report according to MMSEA; and
- failure to properly reimburse Medicare for conditional payments

As the *United States v. Stricker* case demonstrates, liability under the MSP can dwarf exposure under MMSEA
Complying With Reporting Requirements of MMSEA

I know so much I don't even know what I know...
1. Register with CMS

- Responsible Reporting Entity (“RRE”): any entity that is or may become liable to CMS as a “primary plan”

- September 30, 2009: RREs that expect to have something to report were required to begin registering

- February 24, 2010 Alert: RRE will be deemed compliant for registration if (1) it completes the registration process with COBC to begin working toward reporting the required data or (2) it notifies COBC of inability to register during its initial designated timeframe and subsequently registers during a later timeframe approved by COBC
2. Determine Plaintiff’s Status

- **What:** RREs must determine the status of all plaintiffs with whom claims are settled on or after October 1, 2010

- **Who:** RREs bear the sole responsibility for accurately determining a plaintiff’s status

- **How:** RREs must “implement a procedure” to determine plaintiff’s status

- **When:** RREs have ongoing duty to determine a plaintiff’s status
3. Reporting

- Electronic: **all reporting must be done electronically**
- January – March, 2011: **deadline for RREs to submit first reports for claims settled after October 1, 2010**
- Required Information:
  - Plaintiff’s name, DOB, SSN or HICN
  - CMS currently requires over 60 categories of information, including identifying information, date of injury, cause of injury, and description of injury allegedly caused by RRE or its insured
  - CMS expanded to expand up to over 100 categories of information about the claim, including ICD-9 codes for cause of injury and injury allegedly caused by RRE or its insured
  - RREs must keep existing reports updated and correct
RRE Registration

Registering RREs within a corporate structure

- A parent company *may* register as a RRE for a direct subsidiary whether or not the parent qualifies as an RRE
- A subsidiary company *may not* register as an RRE for its parent
- An entity *may not* register as an RRE for its sibling company
- A captive is considered a subsidiary of its parent entity and a sibling of any other subsidiary of the parent

Foreign Entities as RREs

- must register between April 5 and January 1, 2011
- should apply for Employer ID number (EIN) from IRS
What Claims Are Reportable?
Exempt Reporting Amounts

- Prior to January 1, 2012: $0 - $5,000
- January 1, 2012 through December 31, 2012: $0 - $2,000
- January 1, 2013 through December 31, 2013: $0 - $600
- No thresholds after January 1, 2014
Effect of Indemnification

- CMS recently stated that a party who is fully indemnified as part of a suit/settlement is *not* the RRE for MMSEA reporting purposes for that particular claim.

- Instead, the party making the payment - the indemnifying party - would be the RRE and would be required to report.

- Marks a departure from prior CMS statements regarding indemnification.
Excluded Claims

- **Date of exposure before December 5, 1980**
  - No exposure on or after December 5, 1980 “alleged, established and/or released”
  - Specific to a claim/defendant

- **Unless claim involves continuing exposure beyond December 5, 1980**

- **Burden of documenting on RRE**
When Are Claims Reported?
Timeframe to Report Claims

- **TPOC Date**: date agreement obligating RRE to pay a claim is signed unless court approval is required

- **January – March, 2011**: period for submitting initial reports of claims after testing

- **Quarterly Reporting**: within the 7 day file submission timeframe assigned to RRE

- **45 day Grace Period**: if TPOC date occurs 45 days before file submission period then claim reported during the next quarter
MSP Reimbursement Obligations

- Claimant obligated to reimburse Medicare for conditional payments within 60 days

- RRE responsible for reimbursing Medicare if claimant does not -- even though RRE has already paid claimant for monies to be used for reimbursement
  - CMS may recover *double damages* if legal action is required to secure payment from the RRE

- The result is potential *triple liability* for the RRE

- CMS has stated that the statute of limitations for recovery actions is six years from the *time CMS becomes aware of the claim*
United States v. Stricker: A Cautionary Tale

- On December 1, 2009, the US Department of Justice filed a civil action to recover conditional payments that were made to approximately 907 Medicare beneficiaries involved in a $300,000,000 class action liability lawsuit named the Abernathy Settlement.
- Defendants include Plaintiffs’ Counsel, Travelers Indemnity Company, AIG, Monsanto Company, Pharmacia Corporation, and Solutia, Inc.
- The United States is seeking to recover double damages (estimated at $67,156,770.01) as well as interest.
- Case makes clear that Defendants must exercise caution when settling claims involving Medicare beneficiaries, particularly where Medicare has made conditional payments.
Best Practices for MMSEA and MSP
Best Practices

Now:

- Consider a task group or point person to coordinate MMSEA and MSP issues and answer questions
- Identify person(s) who will gather information, query CMS database, and prepare reports
- Determine and communicate assigned 7-day reporting period
- Clearly communicate expectation and procedures, so client and counsel can identify and discussion potential concerns now
- Gather information on existing cases to identify those where MMSEA will be required
- Coordinate with co-defendants and industry trade groups
- Communicate needs and expectations to counsel for existing claimants
Best Practices

During Litigation:

- Obtain discovery on Medicare status and pre-1980 exposure if applicable
- Query CMS database and document results and dates of queries
- Use CMS “safe harbor” documentation where claimant will not provide necessary information
- Communicate early and often with plaintiff’s counsel, so they understand RRE’s obligations and can assist in the process
- Understand scope of injuries alleged by plaintiff and how they may relate to claims against RRE
- Apply claimed injuries to ICD-9 codes to understand scope of conditional payments made by Medicare to claimed injuries
Best Practices

Settlement:

- Assess completeness of information needed for reporting when settlement discussions appear imminent
- Query CMS database upon notice of mediation or other event triggering potential settlement
- Structure settlement to require information needed for reporting
- Incorporate indemnity language and other provisions addressing MMSEA and MSP concerns into the settlement agreement
- Retain discovery and other documents that support decision NOT to report (e.g., discovery showing no pre-1980 exposure)
Best Practices

Settlement (If Medicare Recipient):

- Obtain statement of conditional payments from plaintiff or Medicare at beginning of case and least 60 days before potential settlement

- Consider whether MSA ("Medical Set-Aside") is needed where future medicals are likely
  - CMS recently advised that while MSAs are not legally required, such a set aside is often advisable as the RRE must take steps to protect Medicare’s interests

- Eliminate or minimize exposure to CMS for reimbursement for conditional payments
  - write two settlement checks: one to CMS and one to plaintiff’s counsel
  - establish escrow account holding amount equal to conditional payment
  - obtain letter of satisfaction and indemnity from plaintiff
Implications and Outstanding Questions
Effects on Settlement Strategy

- Adds another hurdle to settlement negotiations
- Increases transactional costs and could eliminate nuisance settlements with Medicare recipients
- Confidentiality is uncertain -- CMS has stated it will not alert RREs to FOIA requests for confidential settlement data and has offered no thoughts on how to protect such information
- Complicates aggregate settlements and other settlement mechanisms where allocation is unknown to the defendant
Issues for Mass Tort Claims

- **Timing of reporting**
  - information often is unknown at time of settlement
  - consider alerting CMS that settlement is imminent
  - report required only when name of claimant is known, allocation of settlement to claimant is known, and funding has occurred

- **Scope of reporting: less detail being discussed**

- **Structuring settlements**
  - cannot “throw money over the wall”
  - defendants can no longer enter into settlements where they do not know individual allocations to Medicare recipients

- **Non-reporting of pre-1980 exposure claims**
  - considering language that would allow broad release where uncontroverted facts show no pre-1980 exposure
  - burden will be on RRE to establish uncontroverted facts
CMS Resources

- General link to CMS website regarding MMSEA: http://www.cms.hhs.gov/MandatoryInsRep/
- CMS Town Hall Transcripts on MMSEA: http://www.cms.hhs.gov/MandatoryInsRep/07_NGHP_Transcripts.asp#TopOfPage
CMS Resources

- CMS comment mailbox on MMSEA issues:
  
  PL110-173SEC111-comments@cms.hhs.gov