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Fool Me Once, Shame on Me; Fool Me Again and You're Gonna Pay For It: An Analysis of Medicare's New Reporting Requirements for Primary Payers and the Stiff Penalties Associated with Noncompliance

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FOOL ME ONCE, SHAME ON ME; FOOL ME AGAIN AND YOU'RE GONNA PAY FOR IT: AN ANALYSIS OF MEDICARE'S NEW REPORTING REQUIREMENTS FOR PRIMARY PAYERS AND THE STIFF PENALTIES ASSOCIATED WITH NONCOMPLIANCE

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"Fool me once, shame on you; fool me . . . and you can't get fooled again."***

—*George W. Bush* (2006)

July 30, 1965—that was the date on which two decades of debate over the national health insurance system that would come to be known as Medicare was signed into law as part of President Johnson's "Great Society" legislation.[1] Since that time Medicare eligibility has expanded and the prospect of its insolvency continues to become more likely.[2] In order to minimize unnecessary expenditures of Medicare funds, Medicare was statutorily deemed to have secondary liability in areas where primary insurers—including self-insurers, liability insurers, group health plans, and workers' compensation insurers—have an obligation to pay for Medicare recipients' medical care.[3] In other words, primary in-

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*** godsroundtable, *Bush "Fool Me Once . . ."*, YOUTUBE (June 24, 2006), http://www.youtube.com/watch?v=eKgPY1adc0A.

1. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at 42 U.S.C. §§ 1395–1395ccc (2006)).

2. *See* Soc. Sec. and Medicare Bd. of Tr., *A Summary of the 2009 Annual Reports*, http://www.ssa.gov/OACT/TRSUM/tr09summary.pdf (last visited Oct. 30, 2010).

3. *See* Jennifer C. Jordan, *Medicare Secondary Payer Enforcement: Shifting the Burden of Medicare to the Private Sector*, 39 THE BRIEF, Fall 2009, at 12, 13 ("[V]irtually no legislative history exists for any of the MSP amendments.").

surers must pay first, or if Medicare pays first, must reimburse Medicare for those payments. Of course, without any meaningful reporting requirements, Medicare funds were continuously expended on medical treatment that should have been covered by primary insurers.[4]

In 2007,[5] faced with growing financial problems with Medicare, Congress—with the passage of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA")—sought to shift the burden of reporting potential primary insurer liability on the primary insurers themselves.[6] At first blush, the MMSEA appeared to contain innocuous sections that simply reinforced Medicare's secondary payer status and its preexisting right to repayment from primary payers. In reality, however, the MMSEA unleashed perhaps one of the largest and most intensive reporting requirements in Medicare history.[7]

Even Medicare's own administrator, the Center for Medicare and Medicaid Services ("CMS"), initially appeared unprepared for the onslaught of reporting that was now mandated by the MMSEA. CMS's creation of an electronic reporting system to streamline the process has largely resulted in confusion and criticism. The new electronic reporting system has been criticized as too complex, and the threat of high noncompliance penalties has generated significant outcry from those responsible for reporting to CMS—referred to as Responsible Reporting Entities

4. *See* Kathryn Bucher & Richard L. McConnell, *New Medicare Reporting Requirements for Self-Insured Businesses Kick In: Many Questions Remain Unanswered*, METRO. CORPORATE COUNSEL (Oct. 4, 2009), http://www.metrocorpcounsel.com/current.php?artType=view&EntryNo=10241 ("Receiving claims through Section 111 reporting will alert Medicare to opportunities to recover conditional payments that previously eluded it.").

5. Notably, the MMSEA was introduced in the Senate, passed by the House, and signed into law by President George W. Bush in just *eleven* days—and immediately prior to the congressional winter break. *See* S. 2499, 110th Cong. § 1 (1st Sess. 2007).

6. *See* Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"), Pub. L. No. 110-173, 121 Stat. 2492 (codified as amended in scattered sections of 42 U.S.C.). In particular, the MMSEA amended the Medicare Secondary Payer Act ("MSPA") adopted in 1980; Section 111 of the MMSEA outlined mandatory reporting requirements, making group health plans ("GHPs"), liability insurers (including self-insurers), no-fault insurers, and workers' compensation insurers responsible for alerting Medicare of its "secondary payer status" in certain claims. *Id.* § 111, 121 Stat. at 2497–99 (codified as amended at 42 U.S.C. § 1395y(b)(7)–(8) (Supp. II 2008)); *see* Russell C. Buffkin & Annie J. Dike, *Navigating the Medicare Reporting Minefield—A Practitioner's Guide to Settlement with a Medicare Beneficiary*, 71 ALA. LAW., May 2010, at 213, 214.

7. *See* Jordan, *supra* note 3, at 14.

("RREs")—demanding that they be provided with more guidance on the specific reporting requirements.

To be sure, Medicare's bark now has bite, and the new legislation likely signals that CMS has a desire to be more aggressive in seeking repayment of Medicare payments and protection of its interest for future medical payments. This, in turn, will leave claimants, insurance providers, and their respective attorneys obligated to ensure compliance with the new onerous (and expensive) reporting policies and procedures.

This article discusses the new requirements and the issues that currently face insurers, claimants, and attorneys in cases involving Medicare-eligible beneficiaries.

I. THE MEDICARE SYSTEM—A HISTORICAL PERSPECTIVE

A brief review of Medicare's inception and evolution is helpful to better understand the current framework of Medicare legislation. First established in 1965 as part of President Lyndon Johnson's "Great Society" movement, Medicare was created as a means to provide government-funded health care coverage for persons over the age of sixty-five.[8] Later, Medicare was expanded to cover select categories of people of a certain age or suffering from a particular disability or terminal disease.[9] Today, Medicare-eligible beneficiaries include individuals who: (1) worked (or whose spouse worked) a specific amount of time in a government job and paid Medicare taxes, (2) have received Social Security disability benefits for at least twenty-four months, (3) presently receive a disability pension from the railroad retirement board, (4) suffer from Lou Gehrig's disease, or (5) are afflicted with end-stage renal disease.[10]

Medicare is divided into four components: Part A relates to hospital insurance;[11] Part B relates to medical insurance;[12] Part C relates to Medical Advantage Plans (Parts A, B, and D typical-

8. Dayna Bowen Matthew, *An Economic Model to Analyze the Impact of False Claims Act Cases on Access to Healthcare for the Elderly, Disabled, Rural and Inner-City Poor*, 27 AM. J.L. & MED. 439, 459 (2001) (citation omitted).

9. *See* Theodore R. Marmor & Gary J. McKissick, *Medicare's Future, Fact, Fiction and Folly*, 26 AM. J.L. & MED. 225, 231 (2000).

10. *See* 42 U.S.C. §§ 426(h), 1395c (2006).

11. *Id.* §§ 1395c to 1395i-5 (2006 & Supp. II 2008).

12. *Id.* §§ 1395j to 1395w-4.

ly);[13] and Part D relates to prescription benefits.[14] Parts A and B are commonly referred to as "Original Medicare" because those benefits were in place during the original enactment in 1965.[15] In 1997, as part of the Balanced Budget Act, Part C was added to provide Medicare beneficiaries with the option of obtaining Medicare benefits through private insurers rather than through Parts A and B.[16] In 2003, Part D was added to provide Medicare beneficiaries with the option of obtaining prescription drug coverage through private insurers.[17]

As Medicare was deemed the primary insurer and payer for medical services required by these beneficiaries, it incurred unanticipated costs that tripled during its first thirteen years.[18] To curb the exorbitant cost associated with its broad coverage, Congress enacted the Medicare and Medicaid Amendments of 1980,[19] otherwise referred to as the Medicare Secondary Payer Act ("MSPA"). The MSPA was designed to shift responsibility for medical payments from Medicare to workers' compensation insurers, group-health plans, and liability insurers where another insurer was responsible for the payment, and also provided Medicare the right to reimbursement for any such payments previously made by Medicare.[20] Under the revised statutory framework,

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13. *Id.* §§ 1395w-21 to 1395w-29.

14. *Id.* §§ 1395w-101 to 1395w-152.

15. *See* Marshall B. Kapp, *Ninny Clients of the Nanny State? Selective Paternalism in Public Benefit Programs for Older Americans*, 6 GEO. J.L. & PUB. POL'Y 191, 198–99 (2008) ("From its creation in 1965 as Title 18 of the Social Security Act until relatively recently, the Medicare program ('traditional' or 'original' Medicare) was split into two parts. Eligible beneficiaries are automatically entitled to Part A Hospital Insurance (HI) consisting of a benefit package (acute hospital care, skilled nursing facility care for a limited period of time, hospice care, and home health care) pre-determined through federal legislation and regulation. Moreover, Medicare Part B, Supplemental Medical Insurance (SMI), covers (as determined by federal law) physician, outpatient, and preventive services.") (footnotes omitted).

16. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275–327 (codified as amended at 42 U.S.C. §§ 1395w-21 to 1395w-28).

17. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071–2152 (codified as amended at 42 U.S.C. §§ 1395w-101 to 1395w-152).

18. *See* Rick Swedloff, *Can't Settle, Can't Sue: How Congress Stole Tort Remedies from Medicare Beneficiaries*, 41 AKRON L. REV. 557, 573 (2008).

19. Medicare and Medicaid Amendments of 1980, Pub. L. No. 96-499, § 953, 94 Stat. 2599, 2647 (codified as amended at 42 U.S.C. § 1395y(b)(2) (2006)).

20. 42 U.S.C. § 1395y(b)(2) (2006); 42 C.F.R. § 411.20 (2009). In the event that a primary payer could not effectively cover the costs associated with a beneficiary's medical care in a timely manner, Medicare would then make the payment for the primary insurer (referred to as a "conditional payment"), provided that Medicare would be reimbursed. 42

Medicare became known as a "secondary payer," and insurers other than Medicare became known as "primary payers."[21] The MSPA did not impose any reporting requirements, however, and thus CMS had the responsibility for determining whether primary payers existed, and if so, whether Medicare made any payments for which the primary payer was responsible. Although the MSPA was a significant modification of the Medicare system, the inability of CMS to effectively monitor the existence of primary payers meant that primary insurers rarely followed through with their obligation to pay or to reimburse Medicare.[22]

In an effort to further reduce the amounts for which Medicare was primarily responsible, Congress amended the MSPA in 2003 to include self-insurers within the group of entities with primary payer responsibility.[23] The amendments defined a "self-insurer" as any entity that "carrie[d] its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part."[24] The amendments also expanded the scope of Medicare reimbursement to provide CMS with a right of recovery against a Medicare beneficiary who received a settlement, judgment, or award.[25] Despite the significant amendments in 2003, CMS still had primary responsibility for identifying primary payers. As a result, Medicare continued to go unreimbursed for funds that should have been paid by primary payers.[26]

U.S.C. § 1395y(b)(2)(B).

21. *See* 42 U.S.C. § 1395y(b)(2)(A) (describing Medicare as a "secondary payer" and insurers other than Medicare as providing the "primary plan").

22. *See* Kenneth Paradis, *New Requirements for Medicare Set Aside Arrangements*, 18 J. WORKERS COMP., Winter 2009, at 31, 32.

23. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 301(b)(1), 117 Stat. 2066, 2221–22 (codified as amended at 42 U.S.C. § 1395y(b)(2)(A)).

24. *Id.*

25. *Id.* § 301(b)(2)(A), 117 Stat. at 2222 (codified as amended at 42 U.S.C. § 1395y (b)(2)(B)(ii)).

26. *See* 101 CONG. REC. S13,419 (daily ed. Sept. 19, 1990) (statement of Sen. Roth) ("Unfortunately, performance under the MSP Program has not measured up. Failure to follow the MSP law is costing the taxpayer billions of dollars. . . . Studies by the General Accounting Office and the inspector general of the Department of Health and Human Services have repeatedly identified the MSP [(Medicare Secondary Payer)] program as gushing with leaks of Federal tax dollars."). The Eleventh Circuit reinforced Medicare's secondary payer status but highlighted the high price of outstanding conditional payments. *See* United States v. Baxter Int'l, 345 F.3d 866, 891, n.16 (11th Cir. 2003) ("To the extent that there is any record of legislative intent at all, it indicates that Congress was dissatisfied that Medicare was not recouping as much from primary payers as it could . . . .").

II. SO WHAT ARE THE NEW REQUIREMENTS?

The MMSEA seeks to alert CMS to instances in which Medicare has "secondary payer" status.[27] As previously discussed, Medicare is a secondary payer when another entity is required—whether by law or contract—to pay medical expenses for Medicare beneficiaries.[28] Thus, Medicare is a secondary payer to all group health plans ("GHPs"), liability insurers (including self-insurers), no-fault insurers, and workers' compensation insurers for claimants[29] who are entitled to Medicare benefits.[30] In the tort liability context, the insurer—or defendant if the defendant is self-insured—does not become a primary payer until a judgment in favor of the plaintiff is entered *or* a settlement between the parties is reached.[31] A liability insurer cannot skirt its status as a primary payer by claiming that none of the funds provided in the settlement were for medical expenses, if the plaintiff claimed medical expenses as part of his or her damages.[32]

Under the MMSEA, any fiduciary or administrator of any such insurer[33] is designated as an RRE.[34] RREs must implement inter-

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27. *See* 42 U.S.C. § 1395y(b)(7)–(8) (Supp. II 2008).

28. *See id.* § 1395y(b)(2)(A) (2006).

29. A "claimant" is defined as "an individual filing a claim directly against the applicable plan; and an individual filing a claim against an individual or entity insured or covered by the applicable plan." *Id.* § 1395y(b)(8)(D) (Supp. II 2008).

30. *See id.* § 1395y(b)(2)(A) (2006).

31. *See id.* § 1395y(b)(2)(B).

32. *See, e.g.*, Memorandum from Gerald Walters, Dir., Fin. Servs. Group for Dep't of Health & Human Servs. Ctrs. for Medicare & Medicaid Servs. to all Reg'l Adm'rs 4 (July 24, 2006) [hereinafter CMS Memorandum], *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/72406Memo.pdf ("Question 9: What happens if a WCMSA proposal received by the COBC on or after January 1, 2006, does not include an amount for future prescription drug treatment? Answer 9: If the cover letter does not include an amount for future prescription drug treatment, and the current treatment records indicate that the claimant has been prescribed drugs and/or may need prescription drugs related to the WC injury in the future, *the submitter did not adequately consider Medicare's interests*.") (emphasis added).

33. In the case of liability insurance, no-fault insurance, or workers' compensation plans,

> an applicable plan shall—(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis; and (ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

42 U.S.C. § 1395y(b)(8)(A) (Supp. II 2008).

34. *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, MMSEA SECTION 111 MSP MANDATORY REPORTING: GHP USER GUIDE 24 (Version 3.0) (Jan. 4, 2010) [hereinafter

nal policies and procedures that comply with the reporting requirements set forth in the legislation and in any subsequent regulations.[35] Although many RREs have balked at the new requirements, many of them already have existing mechanisms in place to determine whether a claimant is Medicare-eligible, for the purpose of determining whether any Medicare lien exists. More significantly, however, the new reporting requirements guarantee that CMS will receive notice of settlements or judgments from which it can seek repayment.[36]

Importantly, CMS has the right to recover any conditional payments made for which Medicare is the secondary payer from GHPs, liability insurers (including self-insurers), no-fault insurers, and workers' compensation insurers.[37] This is true even if a defendant has already made a payment to the beneficiary for those amounts.[38] If repayment is not received in a timely manner, CMS has the right to file suit to recover the amount of the conditional payment.[39] If CMS files suit, it may also recover double damages from the entity with primary payment responsibility.[40] At present, there is no limit—other than the amount of the judgment or settlement—on the amount CMS may seek to recover, and thus the entire value of the judgment or settlement is fair game.[41] A plaintiff, whose settlement would be consumed by the

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GHP USER GUIDE], *available* at https://www.cms.gov/MandatoryInsRep/Downloads/GHPUserGuideV3.pdf; CENTERS FOR MEDICARE & MEDICAID SERVICES, MMSEA SECTION 111 MSP MANDATORY REPORTING: LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS' COMPENSATION USER GUIDE 21 (Version 3.1) (July 12, 2010) [hereinafter LIABILITY USER GUIDE], *available at* http://www.cms.gov/MandatoryInsRep/Downloads/NGHPUserGuideV3.1.pdf.

35. *See* 42 U.S.C. § 1395y(b)(7)–(8).

36. *See id.* (describing information sharing requirements).

37. *Id.* § 1395y(b)(2)(B)(ii) (2006) ("A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.").

38. *See id.* § 1395y(b)(2)(B)(i)–(iv).

39. *Id.* § 1395y(b)(2)(B)(iii).

40. *Id.* ("In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity.").

41. *See* 42 C.F.R. § 411.37(c) (2009). The costs incurred in "procuring" the settlement or judgment is deducted from the total amount Medicare can claim, however. *Id.*

Medicare lien, may request a finding of hardship from CMS so that the lien can be partially compromised.[42]

Medicare's regulatory provisions for workers' compensation settlements make clear that both past and future payments fall within the coverage of the secondary payer requirements.[43] In essence, where a judgment or release covers payment for future medical expenses, Medicare's interests must be adequately protected in the settlement as well.[44] To protect Medicare's interests for future payments, parties typically enter into a Medicare set-aside agreement, whereby pre-approval is obtained from CMS, and the agreement is funded with a certain dollar amount that is treated as the "primary insurer" for future medical treatment.[45] If CMS approves the agreement and future costs of medical treatment exceed the funds set aside, Medicare picks up the additional costs.[46] Unfortunately, Medicare only reviews and approves settlements of $25,000 or more for current Medicare beneficiaries, or $225,000 or more for potential beneficiaries (those who could become eligible in the thirty months following settlement).[47] Even if Medicare does not review the proposed settlement, primary payers are nevertheless obligated to protect Medicare's interests in the settlement. The failure to do so could result in denial of a claimant's coverage, or Medicare seeking repayment from those who received any part of the settlement proceeds.[48]

To facilitate CMS's ability to ensure that Medicare's interests are adequately protected, the MMSEA and accompanying regula-

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42. *See id.* §§ 411.28, 401.61(c).

43. *See* 42 U.S.C. § 1395y(b)(2)(A)(i) (noting that Medicare payments may not be made "to the extent that—payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1)").

44. Even where the settlement doesn't address such payments, the parties and their attorneys must allocate funds for future medical treatment where warranted by the facts. *See, e.g.*, CMS Memorandum, *supra* note 32, at 4 ("Question 9: What happens if a WCMSA proposal received by the COBC [(Coordination of Public Benefits Contractor)] on or after January 1, 2006, does not include an amount for future prescription drug treatment? Answer 9: If the cover letter does not include an amount for future prescription drug treatment, and the current treatment records indicate that the claimant has been prescribed drugs and/or may need prescription drugs related to the WC injury in the future, *the submitter did not adequately consider Medicare's interests.*") (emphasis added).

45. *See* Paradis, *supra* note 22, at 35.

46. *Id.*

47. *See* Memorandum from Gerald Walters, Dir., Fin. Servs. Group for Dep't of Health & Human Servs. to All Reg'l Adm'rs (Apr. 25, 2006), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42506Memo.pdf.

48. 42 U.S.C. § 1395y(b)(2)(A)–(B).

tions placed the burden on RREs to report the identity of all GHP-covered individuals[49] and any claimants[50] who are Medicare-eligible. In addition, RREs must submit a significant amount of information regarding the GHP or the claim[51] online to the Coordination of Public Benefits Contractor ("COBC").[52]

The failure of an RRE to comply with the new reporting requirements carries a penalty of $1000 for each day of noncompliance for each individual claimant.[53] Although quarterly reporting is required, "[m]edicare beneficiaries who receive a liability settlement, judgment, award, or other payment have an obligation to refund associated conditional payments within *60 days* of receipt of such settlement, judgment, award, or other payment."[54] Thus, the new reporting requirements have no impact on the obligation to repay conditional payments.[55]

III. RECENT LITIGATION: REPORTING REQUIREMENTS IN ACTION

Medicare litigation was limited in past decades. However, the federal government is now following through on its threat of recouping outstanding dues from RREs that have failed to inform Medicare of settlements, awards, and judgments involving medical claims and Medicare beneficiaries. The federal government's efforts to recoup payments through the court system has been met with an aggressive defense from RREs who are asking courts

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49. *Id.* § 1395y(b)(7)(A) (Supp. II 2008).

50. *Id.* § 1395y(b)(8)(B).

51. *See* LIABILITY USER GUIDE, *supra* note 34, app. a at 136–78 (setting forth over one hundred different pieces of information that might be included in the submission of a new claim). Similar information is required for reports by GHP RREs, with greater emphasis on the nature of the policy at issue, medical treatment, and policy holder. *See* GHP USER GUIDE, *supra* note 34, app. a. at 119–51.

52. To begin using the online process, RREs are required to sign up for the online service with CMS. LIABILITY USERS GUIDE, *supra* note 34, at 30. Once signed up, RREs are assigned an initial file submission date, on which all individuals for whom submission information is required must submit for the first time. *Id.* RREs are also assigned to a group, which designated when they were required to file quarterly submissions regarding Medicare-eligible claimants and covered individuals thereafter. *Id.* at 44. Existing RREs should have already signed up to participate in the online system, and if they have not done so, should do so immediately. The website URL is http://www.section111.cms.hhs.gov. GHP USER GUIDE, *supra* note 34, at 31; Liability Uses Guide, *supra* note 34, at 30.

53. 42 U.S.C. § 1395y(b)(7)(B)(i), 1395y(b)(8)(E)(i).

54. LIABILITY USER GUIDE, *supra* note 34, at 14 (emphasis added); *see* 42 U.S.C. § 1395y(b)(2)(B)(ii) (2006).

55. *See* LIABILITY USER GUIDE, *supra* note 34, at 14; *see also* 42 U.S.C. § 1395y(b)(2)(B)(ii).

to clarify statutory requirements and protect due process rights against legislative exploitation.

A. *Reimbursement for Conditional Payments*

In December 2009, the federal government initiated a suit to recover conditional payments made on behalf of 907 Medicare-eligible plaintiffs who were involved in a 2003 lawsuit.[56] The case settled for approximately $300 million, and Medicare is now asserting its right to reimbursement.[57] Additionally, because the parties failed to report the settlement to CMS, the government is seeking double payment plus interest in accordance with the MSP statutory penalties, citing a failure to consider Medicare's interests.[58] The pending suit highlights the aggressive means by which the government seeks to recover payments from claimants, insurers, and attorneys in violation of reporting obligations. This increase in collection efforts by CMS has generated significant interest in how attorneys and insurers can properly protect Medicare's interests to avoid claims by CMS.

B. *Clarification of Statutory Obligations*

Among the many concerns regarding the MMSEA's reporting requirements is the obligation to entrust RREs (and CMS) with sensitive information, including claimants' Social Security Numbers and Medicare Health Insurance Claim Numbers.[59] At present, a claimant's beneficiary status cannot be determined without one or the other,[60] and a claimant's failure to provide the identifying numbers prevents an RRE from properly fulfilling its reporting obligations under the MMSEA in the event that "the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or

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56. Complaint, United States v. Stricker, No. 1:09-cv-02423-KOB (N.D. Ala. Dec. 1, 2009).

57. *Id.* at 8–12.

58. *Id.* at 21–24; *see* 42 U.S.C. § 1395y(b)(2)(B)(iii); *see also* 42 C.F.R. § 411.24(c)(2) (2009).

59. *See* GHP USER GUIDE, *supra* note 34, at 51 (discussing the disclosures necessary to ensure that COBC and Medicare have matching records for an individual).

60. *Id.* ("To determine whether an individual is a Medicare beneficiary you must send either a [Health Insurance Claim Number] or [a Social Security Number].").

admission of liability)."[61] Failure to provide the necessary information to the RRE in a timely fashion could result in hefty fines imposed by CMS.[62] Consequently, in *Seger v. Tank Connection, L.L.C.*, the United States District Court for the District of Nebraska reiterated the need for claimant compliance and required the claimant to provide his Social Security Number and Medicare Health Insurance Claim Number to the defendant.[63] The court's ruling is consistent with one of the requirements of the MMSEA—identification of potential Medicare beneficiaries early in the process.[64] By allowing RREs to request relevant information during discovery, they are in a better position to insulate themselves from the stiff penalties associated with noncompliance and to protect Medicare's interests in any settlement, award, or payment.

C. *Due Process Concerns*

Some commentators have suggested that the broad reach of Medicare's reimbursement authority as set forth in the various MSPA, amendments has significant due process implications.[65] For example, CMS is legally entitled to collect for Medicare payments before judicial finality in a disputed matter.[66] As a result, a class of Medicare beneficiaries is challenging the collection processes utilized by the U.S. Department of Health and Human Services ("HHS") when recouping Medicare reimbursement claims in the United States District Court for the District of Arizona.[67] The court has been asked to decide two specific issues: "(1) whether [HHS] can require prepayment of an MSP [(Medicare Secondary Payer)] recovery claim before the correct amount is de-

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61. 42 U.S.C. § 1395y(b)(8)(C) (Supp. II 2008).

62. *See id.* § 1395y(b)(8)(E)(i).

63. No. 8:08CV75, 2010 U.S. Dist. LEXIS 49013, at *19 (D. Neb. Apr. 22, 2010). The statute actually requires that those numbers only be provided at the conclusion of a settlement, award, or judgment, 42 U.S.C. § 1395y(b)(8)(C), but the court seemed to indicate that so long as one is expected, the RRE may request (and receive) the information in interrogatories to streamline the process. *See Seger*, 2010 U.S. Dist. LEXIS 49013, at *18–19. Given the burden on RREs and the potential penalties for noncompliance with the MMSEA, the court found that any burden on the claimant in providing that information in discovery was insignificant. *See id.*

64. *See* 42 U.S.C. § 1395y(b)(7)(B)(i), (b)(8)(C).

65. *See, e.g.*, Jordan, *supra* note 3, at 19.

66. 42 C.F.R. § 411.24(b)–(g) (2009).

67. Haro v. Sebelius, CV 09-134 TUC DCB, 2010 U.S. Dist. LEXIS 38620, at *1–2 (D. Ariz. Apr. 12, 2010).

termined through the administrative appeal procedures, and (2) whether [HHS] can make plaintiffs' attorneys financially responsible if they do not hold or immediately turn over to [HHS] their clients' litigation proceeds."[68] The court will not review specific MSPA claims in the suit, but rather will limit its decision solely to HHS's policies and procedures.[69] The court's ruling could have significant implications for how law firms handle claims throughout the country, as well as the amount of funds that must be set aside, pending a final determination of the amount owed to Medicare.

IV. SO WHY IS COMPLIANCE SO COMPLICATED?

A. *What is the Real Motive?*

The federal government's motive behind the MMSEA is nothing more than an intent to end years of habitual noncompliance with MSP requirements and to provide CMS with the information necessary to ensure that Medicare's interests are adequately protected by primary payers and claimants. For decades, CMS lacked the information to enforce MSPA provisions. As a result, Gerald Walters, director of the financial service group for CMS, estimates that "[a]s of March 31, [2009,] Medicare clients owed the agency $201 million in cases involving secondary insurance payments."[70]

Although the MMSEA appears to be little more than a mechanism by which primary payers—rather than CMS—bear the burden of identifying Medicare eligible beneficiaries and protecting Medicare's interests, there is growing speculation and fear that CMS will utilize the MMSEA to pad its coffers.[71] Some question whether the $1000-per-day, per-claim penalty is a mechanism to ensure proper reporting or to generate revenue.[72] The government

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68. *Id.* at *10–11.

69. *Id.* at *14–15.

70. David Goldstein, *Medicare Won't Let Clients Repay Government, Lawyers Say*, MCCLATCHY WASH. BUREAU (July 10, 2009), http://www.mcclatchydc.com/2009/07/10/71641/medicare-wont-let-clients-repay.html.

71. This is because "[t]he statute specifically funnels all penalties collected into the Medicare Hospital Insurance Trust Fund, which is predicted to exhaust in 2016." Jordan, *supra* note 3, at 16.

72. *See id.* at 16–17 (noting that while CMS states that it has no intention of funneling funds into the Medicare Hospital Insurance Trust Fund, the statury framework could

has already pursued secondary payer reimbursements to recoup compensation for outstanding claims.[73] Given RREs' reporting history, a monetary penalty for noncompliance seems reasonable, even necessary, to force RREs to report claims that previously went unreported. However, the quarterly reporting schedule means that an overlooked or unverified claim can result in a large penalty for an RRE and a sizeable payout for CMS.[74]

Therefore, CMS's complex reporting system coupled with a small window in which RREs can report—intentionally or unintentionally—creates a lucrative enforcement scheme. Unfortunately, the MMSEA's penalties are the law of the land regardless of any secondary motives of CMS. As a result, RREs have no choice but to be diligent in their compliance efforts.

B. *The New Requirements—A "Kitchen Sink Approach" to Claims for Reimbursement*

In the event that an RRE determines that a claimant is a Medicare beneficiary and it expects a payment to result, the entity must inform CMS.[75] As part of the reporting process, CMS requires certain information about the claimant from the RRE, including a classification of the nature and cause of the injury.[76] The classification must be made in reference to the International Classification of Disease, Ninth Revision, Clinical Modification ("ICD-9-CM").[77] Despite its common use and widely accepted classification system, the ICD-9-CM codes may not specifically address the claimants' injuries without opening the door to Medicare asserting reimbursement rights to injuries unrelated to the

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easily be abused).

73. *See, e.g.*, Complaint, *supra* note 56, at 21–25.

74. *See* Press Release, Am. Ins. Ass'n, Trade Groups Ask for Delay in MSP Reporting Requirements (Feb. 5, 2010), http://www.aiadc.org/aiadotnet/docHandler.aspx?DocID=331412 ("[A]s currently envisioned by CMS, failure to report properly a $2,500 automobile medical payment to a beneficiary could subject the reporting entity to a $90,000 fine.").

75. 42 C.F.R. § 411.25(a) (2009).

76. *Id.* § 411.25; *see* Buffkin & Dike, *supra* note 6, at 216 (discussing CMS's reporting requirements).

77. Buffkin & Dike, *supra* note 6, at 216. CMS allows up to five codes to characterize the claimants injuries attributed to the accident. *Id.* Until the implementation of the full reporting requirements in January 2011, CMS will allow RREs to provide a description of the injury or illness in lieu of the codes. LIABILITY USER GUIDE, *supra* note 34, at 52. However, if an RRE chooses to supply a code, "[a] record will be rejected if one code submitted is invalid even if other valid codes are provided." *Id.*

specific claim. "For example, ICD-9-CM codes do not differentiate between right and left appendages. Thus, report of an ICD-9-CM code for a left ankle injury incurred in a car accident may cause Medicare to include in its claim medical bills Medicare paid for an injury to the claimant's right ankle."[78] This can, in turn, cause CMS to grossly overestimate the total amount owed, leaving a disparity between what the RRE reports and what CMS expects.[79] The RRE must sift through the claims CMS believes it is owed, specifying what claims are not related to the incident and explaining the basis for such a determination.[80] The process can be cumbersome, time-consuming, and costly, prolonging the settlement process and frustrating the involved parties.

C. *Difficulties Adjusting to the New Requirements*

In February 2010, CMS delayed full implementation of the obligatory reporting requirements until January 1, 2011.[81] In total, CMS has posted the start date three times, in an effort to accommodate the continued confusion and concern over the new reporting requirements.[82] The latest extension came at the request of the American Insurance Association ("AIA"), the National Association of Mutual Insurance Companies, and the Self-Insurance Institute of America.[83] In its news release, the AIA outlined five major concerns for the impending April 1, 2010, implementation date, including: (1) reporting requirements when more than one RRE share the settlement, (2) privacy concerns for releasing social security numbers and health insurance claim numbers, (3) overall electronic confidentiality and data security, (4) insufficient

78. Buffkin & Dike, *supra* note 6, at 216.

79. *See id.* (discussing the potential communication problems between CMS and an RRE).

80. Medicare then has forty-five days to research the claim and provide the RRE with an update. The entire process must be repeated until Medicare removes all unrelated charges. *See Medicare Secondary Payer Recovery Claim Process*, CNTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.gov/msprecovclaimpro/ (last visited Oct. 30, 2010).

81. Press Release, Am. Ins. Ass'n, CMS Delays Secondary Reporting Requirements (Feb. 17, 2010), http://www.aiadc.org/aiadotnet/docHandler.aspx?DocID=331684.

82. *See* Karl Goring, *Medicare Reporting Rules Require Further Alterations*, NAT'L UNDERWRITER (Apr. 30, 2010), http://www.property-casualty.com/Issues/2010/May-3-2010/Pages/Medicare-Reporting-Rules-.aspx?k=karl+goring.

83. *See* Press Release, *supra* note 74.

electronic testing, and (5) high penalties for RREs when the system may be affected by glitches and unanticipated reporting errors.[84]

In preparation for the new deadline, CMS is continuously updating its resources by issuing updated user guides, posting alerts, and holding teleconferences.[85] Even with additional clarification, some technical aspects of the reporting process are so complex and prone to uncertainty that the lack of a "safe harbor" provision can leave an RRE vulnerable to penalty despite good faith efforts.[86] For example, with regard to the CMS query system, the agency "has stressed that a 'non-match' response should *not* be viewed as confirmation by CMS that the individual is not a Medicare beneficiary. On the contrary, a 'non-match' response only means there was not a match based on the information submitted."[87] Therefore, an RRE can never be completely sure that a claimant is *not* a potential Medicare beneficiary, and it is unclear how RREs are expected to resolve this quandary. Additionally, the CMS-generated fields in the claim input files include information not typically retained by RREs, and "[i]t remains unclear as to whether failure to fill in all fields will generate an error in the file submission for noncompliance determination purposes."[88] Further, an RRE does not have the luxury of assuming or approximating certain claim-related facts for the sake of submitting a completed claim because doing so "could subject the insurer to a claim that it knowingly provided the government false information or, at the least, that it failed to comply with the MMSEA."[89] In sum, the reporting mechanisms in place do not accommodate anything less than a perfect submission—with all 132 fields accurately reported—and as a result, RREs are struggling to define the parameters of their obligations and match their practices with those expected by CMS.

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84. *See id.*

85. *See generally Mandatory Insurer Reporting*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/MandatoryInsRep/ (last visited Oct. 30, 2010).

86. Buffkin & Dike, *supra* note 6, at 215 (noting that without a "safe harbor" provision, receiving false or misleading information from a claimant does not absolve an RRE of liability).

87. *Id.*; *see* LIABILITY USER GUIDE, supra note 34, at 237 (defining Disposition Code 51) ("For queries, the individual was *not* identified as a Medicare beneficiary based upon the information submitted.").

88. Jordan, *supra* note 3, at 15.

89. *Id.*

D. *Protecting Medicare's Interest Outside of Worker's Compensation—To Set Aside or Not to Set Aside*

One of the goals of the new reporting requirements is to provide CMS with sufficient information to seek reimbursement for claims that Medicare has paid but that a primary payer should have paid.[90] There is some debate regarding whether the new requirements were designed to provide CMS with information regarding settlements and judgments that it can use to protect its interests against *future payments* related to the underlying injury.[91] "Currently, it is unclear whether the insurers or insurance carriers have an affirmative duty to Medicare after the case is settled and the reporting is complete."[92] By implementing a reporting scheme, CMS now has the ability to track settlement payments of a beneficiary, and "some attorneys believe [the reporting requirements are] intended to enforce secondary-payer rights against future medical payments, not just past payments. They predict official Medicare set-asides ("MSAs") . . . are just around the corner."[93]

Presently, MSAs are used in workers' compensation cases to provide a sum of money to cover future treatment expenses related to the injury that was the subject of the compromised claim—i.e., to protect Medicare's interests against future payments.[94] However, there is no statutory requirement to provide for such payments outside of the workers' compensation context, and while some RREs are taking affirmative steps to protect Medicare's interest in future payments, others have some apprehension about creating expensive and potentially unnecessary trusts.[95]

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90. CTRS. FOR MEDICARE & MEDICAID SERVS., SUPPORTING STATEMENT FOR THE MEDICARE SECONDARY PAYER (MSP) MANDATORY INSURER REPORTING REQUIREMENTS OF SECTION 111 OF THE MEDICARE MEDICAID & SCHIP EXTENSION ACT OF 2007 (Aug. 1, 2010), http://www.cms.gov/MandatoryInsRep/Downloads/SupportingStatement082808.pdf.

91. *See* Sylvia Hsieh & James Pribek, *New Rules Create Controversy over Medicare Set-Asides*, WIS. L.J. (Feb. 8, 2010), http://www.wislawjournal.com/article.cfm/2010/02/08/New-rules-create-controversy-over-Medicare-setasides.

92. *Medicare Secondary Payer Act (MSP): What Is It? And What Impact Will It Have?*, RUMBERGER, KIRK & CALDWELL (June 8, 2009), http://www.rumberger.com/?t=40&an=872&format=xml.

93. Hsieh & Pribek, *supra* note 91.

94. RUMBERGER, KIRK & CALDWELL, *supra* note 92.

95. *See* Hsieh & Pribek, *supra* note 91.

Additionally, the issue raises several important practical concerns for attorneys. First, attempting to set aside sufficient funds to protect Medicare's interest in future medical payments may make resolution of the case impossible in cases of serious or catastrophic injury. Second, the lack of any clarification from CMS or HHS leaves attorneys unclear as to whether MSAs are necessary outside of the workers' compensation context. Finally, if an RRE chooses to set aside funds to protect Medicare's interests in future payments, it is unclear how much is sufficient to protect Medicare's interests. Although there is a limited preapproval process for MSAs in the workers' compensation context,[96] there is no corresponding process for liability insurers.

Because CMS has established no formal process for reviewing the MSAs of liability payers and has not mandated MSAs outside of the workers' compensation context, it would appear that liability payers may continue to use alternative methods to protect Medicare's interest in a settlement.[97]

V. NEW LEGISLATION—H.R. 4796

On March 9, 2010, Representative Patrick Murphy introduced the Medicare Secondary Payer Enhancement Act of 2010 ("MSPEA").[98] "The bill speeds the Medicare Trust Fund's recovery of medical expenses while streamlining the payment process and providing certainty and finality to all parties to a claim."[99] The proposed legislation has six sections that address issues that plague the MSPA in its present form, detailing specific policies to promote settlement and decrease litigation.

Section 2 of the MSPEA[100] takes up the issue of "calculation and direct payment of MSP Claims."[101] In order to adequately compensate a claimant while also properly considering Medicare's interest, the bill would allow reimbursement to be: (1) based on a good

96. *Workers' Compensation Medicare Set-aside Arrangements (WCMSAs)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/WorkersCompAgencyServices/04_wcsetaside.asp (last visited Oct. 30, 2010).

97. Hsieh & Pribek, *supra* note 91.

98. Medicare Secondary Payer Enhancement Act of 2010, H.R. 4796, 111th Cong.

99. Goring, *supra* note 82.

100. Section 1 provides the short title, and section 2 first addresses the proposed changes. *See* H.R. 4796 §§ 1–2.

101. *Id.* § 2.

faith calculation of costs reflected in billing data and (2) deposited directly into the Medicare Trust Fund.[102] This would effectively allow Medicare's interest to be determined prior to settlement, ensuring that the conditional payments are accounted for in the process.[103] Additionally, the direct deposit option would allow all parties to rest assured that Medicare received payment, relieving RREs from penalties associated with untimely reimbursement. section 2 also places a time limit on CMS to respond to the estimated figure, making an uncontested payment final after seventy-five days.[104] Should CMS dispute the amount, the claimant or RRE may seek resolution of the amount pursuant to an administrative appeals process.[105]

At times, an RRE may compensate a claimant or another RRE directly, and CMS may then be reimbursed from that payment. As such, Section 2 also outlines provisions for this reimbursement method, allowing an RRE or claimant to request a recovery demand letter from CMS beginning 120 days prior to an expected date of settlement, judgment, or award.[106] CMS would then have sixty days to respond with its expected payment.[107] In turn, the claimant or RRE would have another sixty days to make the payment indicated in the final demand.[108] Should CMS fail to provide a final demand for the conditional payment, the claimant or RRE would be absolved of any liability for the reimbursement—free from any obligation for "any item or service related to the request for final demand for reimbursement."[109] CMS would retain the right to initiate an administrative appeal.[110]

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102. *Id.*

103. At present, there are complaints that Medicare demands more money after a settlement if additional charges are found, depriving the negotiating parties from any finality in their settlement agreements. *See* Goldstein, *supra* note 70.

104. *See* H.R. 4796 § 2(a)(1); *see also* Goldstein, *supra* note 70 (highlighting lawyers' complaints that presently "Medicare can be extremely slow to tell them what its share of the settlement should be, taking several months and as much as a year or more").

105. *See* H.R. 4796 § 2(a)(1). The claimant and/or RRE shoulder the burden for proving that the estimated reimbursement amount was correct. *Id.*

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

Section 3 sets a recovery "threshold."[111] The bill proposes that any settlement, judgment, award, or other payment under $5000 would be exempt from all MSP obligations.[112] In an effort to eliminate the waste and excessive expense associated with pursuing small dollar claims, the threshold provisions would place limitations on Medicare's seemingly uninhibited right to reimbursement.

The most anticipated reform is set out in section 4, which creates "reporting requirement safe harbors."[113] This section amends 42 U.S.C. § 1395y(b)(8) by (1) conditioning a penalty on the "intentional nature of the violation" and (2) imposing penalties of various dollar amounts "*up to* $1,000 for each day of noncompliance."[114] Both provisions would substantially alter the extent to which CMS can collect from RREs, virtually eliminating RRE liability for failed good faith efforts by allowing CMS to penalize RREs for intentional violations only.

Section 5 proposes substantial changes to the "use of social security numbers and other identifying information in reporting."[115] It effectively protects beneficiaries' privacy rights by no longer requiring that RREs access and report Social Security Numbers or health identification claim numbers.[116] CMS would have one year from the date of enactment to reconfigure its current reporting requirements to reflect the new provisions.[117]

Section 6 imposes a statute of limitations, restricting the government's ability to bring a cause of action.[118] The date of a Section 111 report will toll the three-year period, thereby providing some finality in claims.[119]

Finally, section 7 establishes the parameters for a user fee.[120] The section creates two scenarios that would carry a nominal fee of thirty dollars payable to CMS.[121] A user fee would attach to a

111. *Id.* § 3.
112. *Id.* § 3(a)(a).
113. *Id.* § 4.
114. *Id.* § 4(1) (emphasis added).
115. *Id.* § 5.
116. *Id.*
117. *Id.*
118. *Id.* § 6.
119. *Id.* § 6(a).
120. *Id.* § 7.
121. *Id.*

direct conditional payment reimbursement, making each payment to CMS subject to the thirty dollar fee.[122] The fee would also attach to any RRE, claimant, attorney, or other interested party requesting a recovery demand letter of conditional payment.[123]

VI. WHAT CAN PRACTITIONERS DO?

Any entity that qualifies as an RRE needs to institute internal policies and procedures to ensure compliance with the new reporting requirements.[124] RREs should begin developing procedures to test the reporting system that is scheduled to go into full effect on January 1, 2011.[125] Specifically, those procedures must determine the Medicare eligibility status of every claimant, even claimants that continue to receive payments from claims settled before July 1, 2009.[126] Because the MMSEA places the burden of determining eligibility on the RRE,[127] companies should determine a claimant's eligibility when it first receives notice of a claim. If Medicare-eligible, and proper notice has been provided to CMS regarding the liability claim, the RRE must await the receipt of a Conditional Payment Letter that reflects Medicare's estimated costs.[128] After sifting through the related (and often unrelated) injuries, the RRE must communicate back to CMS and inform the COBC of any unrelated costs.[129] Unfortunately, this process must be repeated until all unrelated injuries are removed from the payout sheet.[130] After settlement, an RRE must again check to ensure that the claimant is not presently Medicare-eligible and will not be eligible in the next thirty months.[131] An RRE must report any settlements for Medicare-eligible claimants to CMS through a Final Settlement Detail Document.[132] At that

122. *Id.*

123. *Id.*

124. 42 U.S.C. §§ 1395y(b)(7)–(8) (Supp. II 2008).

125. CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDICARE SECONDARY PAYER MANDATORY REPORTING PROVISIONS IN SECTION 111 OF THE MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007—REVISED IMPLEMENTATION TIMELINE (March 29, 2010), http://www.cms.gov/mandatoryInsRep/Downloads/REVTimeline032910.pdf.

126. *See* 42 U.S.C. § 1395y(b)(8)(A).

127. *See id.* § 1395y(b)(7)–(8).

128. *See Medicare Secondary Payer Recovery Claim Process*, *supra* note 80.

129. *See id.*

130. *See id.*

131. *See id.*; *see also* RUMBERGER, KIRK & CALDWELL, *supra* note 92.

132. *See Medicare Secondary Payer Recovery Claim Process*, *supra* note 80.

point, CMS will send a "final demand letter" with the reimbursement amount.[133] Once received, the RRE or claimant must reimburse the stated amount within sixty days, using the approved Check Remittance Form.[134]

VII. CONCLUSION

While the MMSEA and its regulations expand required reporting to new areas, most RREs should have mechanisms in place to deal with the reporting requirements that have existed in the workers' compensation setting. As a result, RREs should look to expand those procedures to include GHPs, liability insurance (including self-insurance), no-fault insurance, *and* workers' compensation insurance. RREs should also see the MMSEA for what it truly is—a mechanism for CMS to track primary payers and ultimately, to seek repayment of past and future benefits to Medicare claimants. Although the MSPEA offers new hope for RREs—proffering some limitations to Medicare's broad reach and subjugating authority—the amendments are merely proposals. Regardless, there is every reason to suspect that "something's got to give." After years of lackadaisical enforcement, the federal government cannot expect that Medicare's pendulum will effectively swing the other way, making RREs, claimants, and attorneys helpless victims of high penalties. Through reformed legislation and clear CMS guidelines, the insurance industry will undergo a transformation that will undoubtedly change the course of future practice, finally enforcing Medicare's status as a secondary payer.

133. *See id.*

134. *See* RUMBERGER, KIRK & CALDWELL, *supra* note 92.

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