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Life Sciences Health Industry Alert

If you have questions or would like additional information on the material covered in this Alert, please contact the author:

Carol C. Loepere
Partner, Washington, D.C.
+1 202 414 9206
cloepere@reedsmith.com

Erik T. Atkisson
Associate, Oakland
+1 510 466 6887
eatkisson@reedsmith.com

Catherine A. Hurley
Associate, Washington, D.C.
+1 202 414 9229
churley@reedsmith.com

…or the Chair of the Life Sciences Health Industry Group,

Michael K. Brown
Partner, Los Angeles
+1 213 457 8018
mkbrown@reedsmith.com

…or the Reed Smith lawyer with whom you regularly work.

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Medicare Secondary Payer Law: New Registration and Reporting Requirements Strengthen Existing Duties and Obligations

The Medicare secondary payer ("MSP") law has been on the books for many years, essentially requiring Medicare to be the "secondary" payer of health benefits for Medicare beneficiaries in situations where another entity is the "primary" payer of health benefits. Determining whether another entity is "primary" and when Medicare is "secondary" has often been difficult because of the wide range of circumstances in which another party may be responsible for a Medicare beneficiary's health expenses, the number of potential parties involved, and the somewhat confusing terminology in the law itself. As a result, Congress enacted new rules to enhance the enforcement of the MSP law. In short, any entity that would cover any health expenses that might pay settlements to Medicare-eligible plaintiffs, or might otherwise compensate Medicare beneficiaries for health expenses as part of group health insurance, workers' compensation, or any other arrangement or plan, needs to become familiar with these new rules.

Congress now requires such entities to (1) *register* as a responsible reporting entity ("RRE"), and (2) *electronically report* information to the Centers for Medicare & Medicaid Services ("CMS") (the agency that administers the Medicare program). CMS will use this information to track and recover health expenses it incurred on behalf of Medicare beneficiaries but that another entity, as a primary payer under the existing MSP requirements, may be responsible for paying.

This Alert provides a brief overview of the existing MSP requirements. It then discusses how the new registration and reporting requirements affect RREs, and what such entities need to do going forward. Although subject to change at CMS's discretion, certain deadlines and associated operational considerations require immediate attention, particularly because entities that fail to comply with the requirements are subject to a penalty of $1000 for each day of noncompliance.

Summary of Existing MSP Requirements

The MSP statute, first passed in 1980, is a "coordination of benefits" provision stating that Medicare is secondary to other medical coverage.[1] In other words, other entities that are considered "primary" are required to pay for covered health services before Medicare does, and must do so without regard to a patient's Medicare entitlement.[2] Medicare is the residual or "secondary" payer and has to pay only if and to the extent that its coverage is greater.

Originally, only workers' compensation carriers were primary payers under the MSP statute. However, the law has been modified several times to expand the types of entities that are "primary" to include group health plans and certain non-group health plan arrangements, such as liability insurance (including self-insurance) and no-fault insurance plans. Any entity that "carries its own risk" with respect to tort liability (including the risk of having to pay a deductible in the event of a claim) may be a "primary plan" and subject to the MSP requirements once its obligation to make medical payments has been "demonstrated."[3] Therefore, the MSP statute is broad and covers any entity that settles claims with potential Medicare beneficiaries.

The basic rule under the MSP statute is that if Medicare pays for items or services where the primary payer should have paid, Medicare can seek to be reimbursed by the primary payer and any provider that has received the Medicare funds. Where the liability of the primary payer has not yet been determined, any payments made by Medicare are "conditional payments." Medicare can seek to recover conditional payments as soon as liability has been "demonstrated" by a judgment, payment conditioned upon a settlement and release (even those containing no admission of liability), or anything else demonstrating the existence of a primary payer.[4]

A product manufacturer, for example, is a primary payer under the Act where it carries any liability for the payment of a claim of medical damages made by a Medicare beneficiary. This most commonly

occurs in the context of a product liability suit. Where a Medicare beneficiary sues a manufacturer alleging its product is defective and caused injury, the manufacturer is a primary payer if it is self-insured for any of the amount it eventually pays to the plaintiff in settlement or as a result of the verdict. An employee group health plan's primary liability (and that of the employer), on the other hand, might simply be demonstrated by the terms of the employee/Medicare beneficiary's particular plan. The primary liability of an employer's workers' compensation carrier for health expenses might be demonstrated where an employee/ Medicare beneficiary was injured on the job.

The statute confers a private right of action for double damages against any primary payer that fails to pay what it owes under the MSP statute.[5]

To date, Medicare has lacked a system of determining the existence of primary payers and the amount it may have overpaid. Therefore, enforcement of the MSP requirements has generally been uncoordinated and inconsistent.

New MSP Reporting Requirements

To improve enforcement of the MSP statute, in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"), Congress established new mandatory reporting requirements for RREs to provide the government with information it needs to collect amounts someone other than Medicare should have paid.[6] Accordingly, RREs must (1) register with CMS and (2) report any payments made.[7]

CMS currently is implementing these MMSEA requirements. Although many CMS guidance documents are available at *http://www.cms.hhs.gov/mandatoryinsrep/* (some of which are voluminous), uncertainty persists regarding what the requirements are, when they take effect, and to whom they apply. To add to the confusion, the requirements have a variety of different names, such as "section 111 mandatory reporting," "mandatory insurer reporting," "MSP mandatory reporting," and "MMSEA reporting." The following is intended to clarify some of the ambiguity and explain the basic mechanics of the registration and reporting processes. More detailed "User Guides" are available on CMS's website.[8]

Registering

Who must register?

Any entity that is a primary payer under the MSP statute meets the definition of an RRE and must register. As discussed above, this includes group health plans and non-group health plan arrangements, such as carriers of liability insurance (including self-insurance), no-fault insurance, and workers' compensation. Any entity that "carries its own risk" with respect to liability is "self insured" and subject to MSP requirements, including the new reporting requirements.[9]

When must RREs register?

For non-group health plan RREs (*i.e.*, liability insurance (including self-insurance), no-fault insurance, and workers' compensation)[10] registration began May 1, 2009 and will continue through *Sept. 30, 2009*.[11]

Once registration is complete, a testing period is required. If no obligation to make medical payments has yet been "demonstrated" (the trigger for MSP liability, as discussed above) and there is nothing to report, registration is not required by Sept. 30, 2009. However, those who do not register initially must register in time to allow a full calendar quarter for testing before reporting begins.[12] Therefore, any reasonable expectation of an obligation to pay health benefits for Medicare beneficiaries, including medical damages (even in part), amounts to a requirement to register as soon as possible.

How do RREs register?

Registration and account setup must be done through a CMS Coordination of Benefits Secure Website ("COBSW") at *www.section111.cms.hhs.gov*. The process involves a number of steps, as discussed below.

What should RREs consider before attempting to register?

Prior to registering, an RRE must make two decisions: (1) who will be the Authorized Representative, Account Manager, and other users; and (2) how many reports will need to be submitted.

Each RRE must nominate an Authorized Representative who must be a company employee (not an outside agent) with legal authority to contract on the RRE's behalf and who ultimately will be

accountable for the RRE's compliance with the reporting requirements. Further, each RRE must assign an Account Manager, who can be either a company employee or an outside agent, to manage the reporting process and control the RRE's online account. Although there can only be one Account Manager for each reporting account, he or she can choose to include other company employees or agents—Account Designees—to assist with managing the account and submitting reports. Account Designees register as users of the COBSW and may access the RRE's account. There is no limit to the number of Account Designees an RRE may have for each account.

Before beginning the registration process, an RRE also must determine how the RRE will submit its files and how many reporting accounts will be needed. Only one report may be submitted on a quarterly basis for each account. Depending on the corporate structure of the organization, its claims tracking procedures, or other considerations, the RRE may want to submit more than one report on a quarterly basis and therefore will need more than one account.

Once these decisions are made, an RRE is ready to begin the registration and account set-up process.

What is the process for registration and account set-up?

To begin registration, an RRE employee must go to the COBSW URL (*www.Section111.cms.hhs.gov*) and select the "New Registration" option. The following information will be required:

- The entity's tax identification number
- Company name and address
- Company authorized representative contact information including name, job title, address, phone and e-mail address
- National Association of Insurance Commissioners ("NAIC") company codes, if applicable
- Reporter type (*i.e.*, liability insurance (including self-insurance)/no-fault insurance/worker's compensation or GHP)
- Subsidiary company information to be included in the file submission for the registration

After registration is complete, a letter containing a personal identification number ("PIN") and an assigned "RRE ID" will be automatically generated and sent to the RRE's Authorized Representative. This information must be furnished to the Account Manager in order to complete the account set-up process. If more than one account is needed because the RRE will be sending in more than one quarterly report, the registration process must be repeated for each account.

To complete the account set-up process, the Account Manager must select the COBSW's "Account Setup" option, enter the PIN and RRE ID, create a log-in name and password, enter certain identifying information, and provide other details as required. Once this is complete, an e-mail will be sent to the Authorized Representative containing a "Profile Report," which the Authorized Representative must sign and return.

Reporting

When will reporting be required?

For non-group health plan RREs (*i.e.*, liability insurance (including self-insurance), no-fault insurance, and workers' compensation), reporting is scheduled to begin April 1, 2010 and reports must be submitted quarterly.

What must be reported?

An RRE must report all Medicare beneficiaries' claims for medical damages it resolves through a judgment or settlement and release, regardless of whether or not there is a determination or admission of liability. In sum, an RRE must report identifying information for the Medicare-eligible injured party (name, social security number, health insurance identification number, gender, date of birth), information regarding the injury (date, alleged cause, description, relevant ICD-9 diagnosis code(s), whether allegedly caused by a product and, if so, identifying information for the product), information regarding available type(s) of insurance, and the name of the injured party's lawyer, among other things.

How can an RRE determine whether a claimant is a Medicare beneficiary?

An RRE can submit data for a claimant as a "query file" in order to request a determination regarding whether the person is a Medicare beneficiary before reporting the claims. The COBC makes

this determination based on the data that is reported in the "query file." This process is optional. Otherwise, the RRE "must implement a procedure in their claims resolution process to determine whether an injured party is a Medicare beneficiary."[13]

Are there any cut-off dates for what settlements must be reported?

Yes. Only settlements that are established as of Jan. 1, 2010 need to be reported.[14] Any settlement that was established before Jan. 1, 2010 does not need to be reported, unless the RRE has continuing or ongoing responsibility for medical benefits.[15] In addition, any settlement that is related to an incident that took place prior to Dec. 5, 1980 does not need to be reported.[16]

How should this information be reported?

The information must be reported in a standard file, formatted according to certain specifications via the COBSW.

Immediate Practical Considerations

In light of the new reporting requirements, a variety of practical issues should be considered by RREs, including how to structure and manage the registration and reporting process internally, how to collect the information that must be reported under the new law, and how to ensure that Medicare is properly reimbursed for any "conditional payments" it may have paid. For example, RREs should consider use of questionnaires to determine whether a person is eligible for Medicare.[17] It also will be important to obtain this information in the early stages of discovery when any plaintiff seeks compensation for health expenses. Similarly, in crafting settlements, companies should obtain indemnification for any medical liens or recovery actions pursued by the Medicare program.

If you have any questions about the new registration on reporting requirements, or need assistance with developing a registration and reporting strategy for your entity, please do not hesitate to contact the authors, or any other Reed Smith attorney with whom you work.

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1 *See* Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, § 953, 94 Stat. 2599 (1980).

2 *See* 42 U.S.C. § 1395y(b) (Social Security Act § 1862(b)) and 42 C.F.R. Part 411.

3 *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. Law 108-173, § 301, 117 Stat. 2066, 2221 23 (2003) (pertinent portion codified at 42 U.S.C. § 1395y(b)(2)(A)).

4 Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9319, 100 Stat. 1874 (1986) (codified at 42 U.S.C. § 1395y(b)(2)(B)).

5 42 U.S.C. § 1395y(b)(3)(A).

6 Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"), § 111, Pub. Law No. 110-173, 121 Stat. 2492 (Dec. 29, 2007).

7 *See* MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (Including Self-Insurance, No-Fault Insurance, and Workers' Compensation) USER GUIDE ("Liability Insurance User Guide") at 15 (CMS, Mar. 16, 2009); MMSEA Section 111 MSP Mandatory Reporting GHP USER GUIDE ("GHP User Guide") at 15 (CMS, May 22, 2009).

8 The Liability Insurance User Guide is available at http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf. The GHP User Guide is available at http://www.cms.hhs.gov/MandatoryInsRep/Downloads/GHPUserGuideV2.3.pdf.

9 *See* Liability Insurance User Guide at 179.

10 Different deadlines and requirements apply to group health plan RREs. See CMS, Revised Implementation Timeline," (May 12, 2009) *available at* http://www.cms.hhs.gov/MandatoryInsRep/Downloads/RevisedImplementationTimeline050909.pdf. The remainder of this alert will address only the requirements that apply to non-group health plan RREs.

11 The Liability Insurance User Guide published March 16, 2009 states that these types of RREs only have until June 30, 2009 to register. However, CMS published a memorandum dated May 11, 2009 extending the registration deadline: "The registration period for liability insurance (including self insurance) no-fault insurance, and workers' compensation RREs has been extended. RREs now have from May 1, 2009, through September 20, 2009 to register." The registration dates could be subject to further change at CMS's discretion.

12 *See* Liability Insurance User Guide at 22.

13 *See* Liability Insurance User Guide at 67–68. Group health plans will also have access to a database in order to determine the Medicare eligibility and enrollment of up to 200 covered individuals per month. *See* GHP User Guide at 98.

14 *See* "ALERT for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Responsible Reporting Entities" published by CMS *at* http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPV10UserGuide051109.pdf (May 11, 2009).

[15] *See* Liability Insurance User Guide at 52.

[16] *See* Liability Insurance User Guide at 58.

[17] Medicare has published a model questionnaire (*see* Medicare Secondary Payer Manual (CMS Pub. 100-05), Ch. 3 § 20.2.1) to aid providers and suppliers with screening Medicare beneficiaries for alternate health coverage sources, which they are required to do under the MSP statute. *See* 42 U.S.C. § 1395y(b)(6). An RRE could develop a similar questionnaire to identify possible government payers, including Medicare and Medicaid.

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