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New Law Spells MSP Relief for Private Sector

There seems to be growing awareness that engaging in a "business, trade, or profession"[1] can easily subject any person or entity to what is known as the Medicare secondary payer ("MSP") law—a series of provisions in Title XVIII of the Social Security Act, governing the hierarchy of who pays first among applicable insurers.[2] Given its scope and complexity, understanding and complying with the MSP law can be overwhelming. Further, although failure to comply carries obvious risk, conforming to what the law requires may also trigger certain risks of its own. To recap, and for those who remain unfamiliar with MSP and its challenges, the following summarizes one typical scenario:

An injured Medicare beneficiary blames your business for certain injuries, seeking compensation, which you promise to pay in order to settle the matter. By operation of law, this makes you a "self-insured plan" of liability insurance.[3] You also become the primary[4] payer for past and future medical expenses associated with the injury (known as "conditional payments"[5]), while Medicare becomes secondary.[6] This means that unless the beneficiary pays Medicare back out of the settlement proceeds or otherwise, you become liable to Medicare for any costs Medicare has incurred, or will incur, to treat that beneficiary's injuries.[7] In fact, you could be liable for double damages (twice what Medicare is owed),[8] and as an entity that has no direct relationship with the Medicare program, you have no clear administrative appeal right in connection with any repayment demand. Not only that, but under section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA),[9] you have an affirmative obligation to report the settlement to Medicare,[10] essentially inviting Medicare, to the extent it has incurred costs in connection with the beneficiary's injuries and has not yet been paid back, to collect its refund from you. To make the required report, you must jump through a series of complicated and resource-consuming hoops, to include, among other things, registering as a reporting entity, obtaining a reporting "ID," test reporting, and ensuring reportable data is collected and converted into the correct format.[11] If you fail to report the payment to Medicare because, for example, you are not even aware that the injured claimant is a

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Medicare beneficiary, you are liable for penalties of $1000 per day that the settlement goes unreported, indefinitely.[12] Thus, your settlement may subject you to additional, significant financial risk, despite intentions to the contrary.

Other scenarios in which MSP liability, including reporting liability, can arise include, among other things, clinical trial sponsors that promise to pay for subject injuries (for example, in an informed consent) where the subject is a Medicare beneficiary, and settlements involving a promise to pay for the injured beneficiary's medical expenses, instead of paying a lump sum. Like the scenario discussed above, such contractual obligations to pay make the promisor a "self-insured plan" of insurance subject to MSP liability and mandatory reporting.[13]

The Centers for Medicare & Medicaid Services (CMS) has now been working on implementing the MMSEA section 111 mandatory reporting component of the MSP program for five years, which appears to have been a trying exercise for regulators and regulated alike. Meanwhile, in October 2012, the U.S. Department of Health & Human Services ("HHS") Office of Inspector General ("OIG"), added MSP reporting compliance to its annual "work plan" for 2013, for the first time suggesting that possible enforcement activity could be on the horizon.

Amid consensus that the existing situation demands improvement, Congress recently passed the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012, commonly referred to as the SMART Act provisions—new legislation signed January 10, 2013 that addresses at least a few of the acute challenges presented under the existing MSP system.[14]

Although it does not change the basic premise that a promise to pay an injured beneficiary is tantamount to a plan of liability insurance that is primary to Medicare, or generally relieves parties from their reporting obligations, the Act should give parties that make payments to Medicare beneficiaries at least some opportunity to control the process and the outcome, and alleviate some of the more draconian qualities of the current system.

Below is a summary of each MSP provision in the Act, and a brief analysis of the effect these changes will have:

Access to Medicare Claims Information Through CMS Website, Improved Program Efficiency (Section 201)—Amends Section 1862(b)(2)(B) of the Social Security Act by adding several new clauses as follows:

- (vii)(I)—To the extent the Secretary has made a conditional payment, the claimant or the *applicable pla*n can notify the Secretary that a settlement, judgment, award, or other payment is reasonably expected within 120 days of the expected date. Under the existing process, the Secretary, through its Coordination of Benefits Contractor (COBC) and its Medicare Secondary Payer Recovery Contractor (MSPRC), only accepts such notice from the beneficiary, or his or her representative.

- (vii)(II)—Requires the Secretary to maintain a website containing Medicare claims information (including conditional payment information), and provide access for beneficiaries and any applicable plan that has obtained the beneficiary's consent.

Further requires the Secretary to update the Medicare claims information available on the website within 15 days of paying a claim. Among other requirements, claims that are related to a potential settlement must be accurately identified as such on the website. Currently, the MSPRC only provides claims information to beneficiaries in a "conditional payment letter" (CPL), which is generated automatically, but only after 65 days have passed since certain triggering events have occurred (over which the plan generally has little control), and then only upon a beneficiary's request, not to exceed every 90 days. The liability insurer can be copied on the CPL, but only if the beneficiary signs a consent to release. Even where the liability insurer obtains a copy of the CPL, it can never be certain whether the conditional payment information reflected is accurate or up to date.

- (vii)(III)—If a claimant or applicable plan downloads conditional payment information (referred to in the Act as a "statement of reimbursement") from the website discussed in (vii)(II) within a certain period of time of the settlement date—defined as the "protected period" (see below)—that statement of reimbursement constitutes the "final conditional amount." Under the existing system, "final" conditional payment information is not available from the MSPRC until it issues a demand letter after the settlement date, so that settling parties, at the time of settlement, have little-to-no information to rely on with respect to Medicare's expected refund. Even once the demand letter is received, there is no guarantee of actual "finality," and the issue of how to deal with future medicals thus poses a significant dilemma for settling parties.

- (vii)(IV)—Requires the Secretary to provide a timely process for resolving discrepancies that the beneficiary (or his or her representative) identifies in the statement of reimbursement (for example, claims erroneously identified as "related" to the settlement, thereby improperly increasing Medicare's refund amount). Specifically, the Act gives the Secretary only 11 business days from when the Secretary receives documentation on the discrepancy to determine whether there is a reasonable basis to remove the disputed claims from the statement. If the Secretary fails to make a determination within 11 business days, the discrepancy must be resolved pursuant to the beneficiary's proposal. At present, there is no process to challenge erroneous COBC determinations regarding what claims are related to the settlement.

- (vii)(V)—Describes how to calculate the "protected period," during which time the parties can rely on a downloaded "statement of reimbursement" as Medicare's "final" notice of any refund Medicare is owed pursuant to (vii)(III) above.

- (viii) Requires the Secretary to promulgate regulations establishing a right of appeal and an appeals process by which an applicable plan can challenge MSP collections actions. Currently, there is no clear pathway for an *applicable plan* wishing to appeal an MSP liability determination and pursue judicial review without inviting jurisdictional attacks for failure to exhaust administrative remedies.

Minimum Thresholds for Certain Claims (Section 202)—Amends section 1862(b) of the Social Security Act by establishing an exception to MSP liability and to MSP reporting obligations for liability insurance plans where the injury involved "physical trauma" and not "ingestion, implantation, or exposure," and where the settlement amount falls below a threshold amount, to be calculated and published annually consistent with a specific

formula. Although the Secretary has established "interim reporting thresholds" for liability insurance that exempt smaller settlements from having to be reported, these thresholds are discretionary, subject to change at any time, and there is no transparency with respect to how they are calculated. Further, there are no minimum thresholds that exempt smaller settlements from triggering Medicare's refund requirement.

Changes to MMSEA Section 111 Reporting Requirement Penalties, Safe Harbors (Section 203)—Amends section 1862(b)(8) of the Social Security Act as follows:

- First, the mandatory language addressing civil money penalties ("CMPs") of $1000 per day for liability insurance plans that fail to report payments to Medicare beneficiaries in accordance with MMSEA section 111, was changed to permissive language. This appears to provide the Secretary with discretion regarding whether to impose CMPs for failure to report.

- Second, Congress is requiring the Secretary to promulgate regulations addressing circumstances under which CMPs—for failure to report payments—will and will not be imposed, including a regulation addressing an exception to CMPs where the liability insurance plan makes good-faith efforts to identify whether a claimant is a Medicare beneficiary. The Act orders the Secretary to issue a proposed rule within 60 days, and afford the public a 60-day comment period. This is significant because, until now, the public has had virtually no meaningful input with respect to any mandatory reporting policy matters, including significant policy concerns about mandatory reporting shared by many clinical trial sponsors, among others. In addition, MMSEA section 111 imposed penalties for failing to report even where such failure was based on unavoidable mistake—that is, the reporting entity attempted in good faith, but failed, to correctly identify whether a claimant was a Medicare beneficiary; for example, because the plaintiff gave the reporting entity incorrect identifying information.

Obtaining Claimant Social Security Numbers and Other Identifying Information for Reporting (Section 204)—Directs the Secretary to modify the requirements for what information liability insurance plans must report pursuant to MMSEA section 111, so that plans are no longer required to report beneficiary Social Security numbers or Medicare health identification claim (HIC) numbers. When Congress enacted MMSEA section 111, it gave the Secretary discretion to determine what information liability insurance plans would be required to report, and pursuant to that authority, the Secretary developed a list of required data elements,[15] including the beneficiary/claimant's Social Security number or HIC number, which can be difficult to obtain.

Statute of Limitations (Section 205)—Amends section 1862(b)(2)(B)(iii) by establishing a three-year statute of limitations for commencing an action against any type of primary payer (for example, a liability insurance plan, *or* a group health plan) to recover conditional payments and/or double damages.

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1 U.S.C. § 1395y(b)(2)(A).

2 42 U.S.C. § 1395y(b).

3 42 U.S.C. § 1395y(b)(2)(A); 42 U.S.C. § 1395y(b)(2)(B)(ii).

[4] 42 U.S.C. § 1395y(b)(2)(A).

[5] 42 U.S.C. § 1395y(b)(2)(B).

[6] 42 U.S.C. § 1395y(b)(2)(A)(ii); 42 C.F.R. § 411.22(b)(3) (a primary payer's responsibility for payment may be demonstrated by any means, including, among other things, a "contractual obligation").

[7] 42 U.S.C. § 1395y(b)(2)(B)(ii).

[8] 42 U.S.C. § 1395y(b)(2)(B)(iii).

[9] Codified at 42 U.S.C. § 1395y(b)(7) – (8).

[10] 42 U.S.C. § 1395y(b)(8)(A).

[11] *See generally* CMS, MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation USER GUIDE (hereinafter referred to as "NGHP User Guide"), *available at* http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/NGHP_User_Guides.html.

[12] 42 U.S.C. § 1395y(b)(8)(E).

[13] Group health plans are also subject to the MSP law. However, with the notable exception of the new statute of limitations discussed in paragraph 5 below, the changes resulting from the Act discussed here primarily affect liability insurance plans (including self-insurance), no fault insurance, and workers' compensation plans. These types of primary payers will be collectively referred to in this summary as "liability insurance," "liability insurers," or "liability insurance plans."

[14] Among other things, the Act also requires the Secretary of HHS to implement a demonstration project to evaluate the benefits of providing Medicare Part B payment for items and services needed for the in-home administration of intravenous immune globin (IVIG) for the treatment of primary immune deficiency diseases. A discussion of this demonstration project and other provisions within the Act is beyond the scope of this summary.

[15] *See* NGHP User Guide, Appendix A *available at* http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/Downloads/NGHPUserGuideVer34Ch5Appendicies.pdf.