

May 1, 2009

# The Medicare Secondary Payer Law and SCHIP Extension Act

---

**What you need to know  
to remain in compliance.**

PRESENTOR

**John V. D'Alusio**

*EVP, Senior Claims Officer  
Avizent*



## Five Reference Points

---

- **The Omnibus Budget Reconciliation Act of 12/5/80**
- The Code of Federal Regulations (Section 411.20-411.50)
- Circulars from CMS  
(Centers for Medicare and Medicaid Services)  
outlining enforcement and review procedures with  
multiple memoranda between 7/23/01-4/3/09)
- Jurisprudence on Tort Cases
- **Medicare, Medicaid and SCHIP Extension Act of 2007**



# The Medicare Secondary Payer Act

## Omnibus Budget Reconciliation Act of 1980

- Purpose: Reduce federal spending of Medicare benefits
  - Medicare is a “secondary payer” whenever a primary payer exists
- “Medicare’s interest must be taken into consideration in all settlements”
  - Determination of “consideration” is ambiguous



# The Medicare Secondary Payer Act

## Code of Federal Regulations (42 CFR 411.20 through 411.50)

**Purpose:** Enforce the parameters of the law

“...precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under any of the following:”

Workers' compensation

Liability insurance

No-fault insurance



# MSP Enforcement

## Enforcement Agency

The Centers for Medicare and Medicaid Services (CMS)

## Enforcement Actions - Circulars

Procedures and programs for adherence created via administrative fiat.

Memo dated 7/23/2001

First notification to insurance industry to protect Medicare as Secondary Payer

Last memo dated 4/3/09

Methodology of pricing prescription medications



# The Medicare Entitlement Test

## Injured party is Medicare entitled at the time of settlement

- Age (65 or older)
- SSDI Dependent for 24 months
- Catastrophic injury/mortal condition

## Potential Medicare entitlement of injured party within 30 months of settlement date

- Filed for SSDI
- Collecting SSDI for less than 24 months
- 62 ½ years of age



Efficiency 1.3 Million We have the a  
With years of experience, you can trust in us. With years of experien  
Understanding Risk you can trust in us.  
Our focus is on creating programs customized to meet your unique needs. Understanding

# CMS Submission Policy for MSAs

## Injured Party Medicare Eligibility Status:

**Entitled to Medicare at time of settlement:**

**If settlement (indemnity, medical, claimant attorney fees combined) is \$25,000 or more, the MSA should be submitted to CMS for pre-approval prior to settlement.**

**If the settlement is under \$25,000, Medicare must still be protected, but the MSA does not have to be submitted to CMS for pre-settlement approval (CMS retains right of retrospective approval).**

**Not entitled to Medicare at time of settlement:**

**Potential eligibility within 30 months from date of settlement:**

**If total settlement is \$250,000 or more, CMS desires pre-settlement approval.**

**If settlement is under \$250,000, pre-approval by CMS is not required.**

**NOTE: The submission policy for MSAs is not the Medicare Entitlement Test.**



## Remedies if Medicare is Not Protected

---

- Medicare's right of secondary payer protection derives from statute (Title 42), not "stare decisis."
- Medicare cannot overturn a settlement that has been approved by a court of competent jurisdiction. However, they can initiate a separate cause of action forcing the parties to reopen the claim to respond to Medicare's legal action if a "right of recovery" is enforceable.
- Medicare can suspend entitlement benefits to the claimant for the condition for which the case was settled and take credit to abide in the amount of the entire settlement.
- Potential "Bad Faith" exposure if the claimant loses their right to a federal entitlement program because the primary payer did not obey the secondary payer law.

Efficiency 1.3 Million We have the a

With years of experience, you can trust in us. With years of experien

Understanding Risk you can trust in us.

Our focus is on creating programs customized to meet your unique needs.

Our focus is on creating programs customized to meet your unique needs.

Understanding

# How is an MSA Funded and Administered?

## Funding can be one of two ways:

Cash

Annuity – The preferred methodology

The MSA money is placed in an interest bearing account in a bank.

## Administration of the MSA: Who gets the checkbook?

Self-Administration by the claimant

Third Party Administration –

Requires an annuity to pay the administrator who charges on an annual basis



## Key Issue: Injured Party Medicare Eligibility

### Determination of eligibility status

Date of Birth

Secure an SSA-3288 release

SSDI application effectively makes a claimant Medicare eligible within 30 months of the date of settlement according to CMS.

Age alone is not sole criterion for Medicare eligibility

Additional criteria include:

Catastrophic Injury

Mortal Condition

Collection of SSDI for 24 Consecutive Months



## MSP Jurisprudence: Tort Claims

- USA vs. Baxter International
  - 9/15/2003: 11<sup>th</sup> Circuit Appellate Decision
- J. Brown v. Tommy Thompson & U.S. Department of Health & Human Services
  - 7/7/2004: 4<sup>th</sup> Circuit Court Appellate Decision
- J. Avery v. RJF International
  - 1/8/2004: 1<sup>st</sup> Circuit Court Decision
- Estate of T. Urso v. Thompson Supermarket
  - 3/10/2004: District Court of Connecticut Decision  
309 F. Supp. 2d 253

**Precedents Set in Adjudications**  
**Admission of Liability Not Required**  
**MSP Retroactive to 1981**  
**Prompt Payment Not Required**



## MSP Jurisprudence: Tort Claims

- Thompson v. Goetzmann  
337 F. 3d 489 (USCA 5th Cir. 2003)

Two hip replacements paid by Medicare  
- Hip replacements found defective

Claimant filed product liability suit against the manufacturer of the prosthesis

- Case settled with the manufacturer
- Settlement paid the claimant without insurance contribution



## Thompson v. Goetzmann (continued)

- CMS seeks reimbursement of Medicare expenditures

Action filed through US Office of General Counsel against:

Claimant

Manufacturer

Claimant's Attorney

- Plaintiff Allegations

Manufacturer's payment to settle claim amounted to a "self-insured" plan under Title 42.

Therefore, the parties are subjected to the MSP.



## Thompson v. Goetzmann (continued)

- **Decision Rendered by the 5<sup>th</sup> Circuit (TX)**

Medicare not entitled to recovery under MSP

Manufacturer not an entity providing insurance coverage

MSP Act Not Applicable

No “prompt payment” made by the defendant

Required under Section 1395y(b)(2)(A)(ii)



# Impact of the Goetzmann Case

## STATUTORY REVISIONS

Title 42, Chapter 7, Subchapter 18, Section 1395y reviewed by Congress

Code of Federal Regulations (Title 42, Part 411, Subpart B, Section 411.20 through 411.46) tightened up

Medicare Prescription Drug, Improvement and Modernization Act of 2003

**"Prompt Payment"** language removed

Right of Recovery to the extent that payment:

"has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

*Section 1395y(b)(2)(A)(ii)*



# MSP Jurisprudence: Tort Claims

## Revised Definition of Self-Insured Plan -

"An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part."

*Section 1395y(b)(2)(A)(ii)*

## Protection of Medicare's Interest with or without determination of liability -

"A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether of not there is a determination or admission of liability) of payment of items or services included in a claim against the primary plan or the primary plan's insured, or by other means."

*Section 1395y(b)(2)(B)(ii)*



## Recent Legislative Action

### Medicare, Medicaid and SCHIP Extension Act of 2007

12/29/2007: Signed into law by President Bush

Section 111 (p. 18-22): Medicare Secondary Payer Act

“Required submission of information by or on behalf of liability insurance (including self-insurance), no fault insurance and workers’ compensation laws and plans”

Primary Payers Responsibilities:

- Determine entitlement of claimant to Medicare benefits on any basis
- Submit entitled claims to Medicare



## Medicare, Medicaid and SCHIP Extension Act of 2007 (continued)

“...submit [information]...within a time specified by the Secretary [of Human Health and Services] after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).”

### Non-Compliance Penalties

- “Civil money penalty of \$1,000 [per file] for each day of non-compliance with respect to each claimant.”
- Fining ability does not obtain until 7/1/09



## The Impact

### Impact of the Medicare, Medicaid and SCHIP Extension Act of 2007 on Property & Casualty

Claimant's Medicare entitlement status must be determined

- Responsibility of all claim handlers
- Training Procedures must be modified
- Attorneys must routinely attempt to delineate Medicare Entitlement Status via depositions and interrogatories
- Data elements must be added to claim systems (over 100 fields)
- **IT Departments Beware!!!! EDI and Monthly query responsibilities**

Reporting of applicable claims to Medicare above established "thresholds"

- Form and format has been determined by Medicare



## The Impact

### Impact of the Medicare, Medicaid and SCHIP Extension Act of 2007 on Property & Casualty

#### Potential Fine

Law requires compliance mandates for:

- Liability Claims (including FELA)
- No-Fault Claims
- Workers' Compensation (including USL&H Act and FECA)
- \$1000 per day for each day of non-reporting
  - Quarterly reporting: Applicable for all report qualifying cases



## SCHIP Reporting

- The reporting elements and frequency were published by CMS in August 2008. The 180 page User Guide was released by CMS on 3/16/09.
- Three methods of electronic reporting accepted; direct from the RRE, via an Account Manager, or via a Third Party Aggregator.
- Reporting required of claims “in process” when it is determined that the injured party is Medicare entitled. If the claimant is Medicare entitled, and you make an indemnity or medical payment, report if the thresholds are met.
- Frequency is quarterly (over 100 data elements required for each file being reported).
- No “Safe Harbors” are provided.
- Fining legally allowed as of 7/1/09 but will commence as of 1/1/2010.
- CMS has an electronic mailbox to allow for questions.
- CMS is creating a website that will walk you through the statutes and provide information on this legislation.
- Required Reporting Entities (RREs) must register on the CMS website between 5/1/09 and 6/30/09. However, on the 4/21 CMS “Town Hall” meeting, the window was extended beyond 6/30/09.
- A monthly database inquiry will be allowed to determine Medicare entitlement status of injured individuals. Four data elements required. (name, DOB, SSN or HISN, and gender must be supplied).



## Who is an RRE????????

---

- On Guaranteed Cost insurance programs, or fully insured programs, the insurance carrier is the RRE.
- On Deductible Programs, if the carrier funds the losses within the deductible and above the deductible, the carrier is the RRE.
- If the account funds loss payments within the deductible, the account is the RRE.
- On Self- Insured programs, the account is the RRE.
- Excess Insurance, the carrier may become the RRE if they take over handling and funding of the payments.
- If the account is receiving reimbursement from the carrier and the account continues funding payments to the claimant, the account is the RRE.
- **Key – Whoever is the primary funding agent of the claim loss payments is the RRE**

## CMS 3/20/09 Alert

---

- **Permissible Testing Period Extended to 12/21/09.**
- **“Interim” reporting thresholds in Liability and WC established**
- WC (for 2010)– Excluded from reporting on ORM cases: MOs, Lost Time cases of no more than 7days, Total payments not exceeding \$600, All payment(s) has/have been made directly to the medical provider.
- Liability, For TPOC (Total Payment Obligation to the Claimant) – For 2010 any case with payments below \$5,000 are exempted from reporting, for 2011 any case with amounts below \$2,000 are exempted, for 2012 claims with payments below \$600 are exempted.
- **Registration information have been modified. See Section 8 of the latest User Guide for the changes.**
- **Error in the Field Descriptions on the TIN Reference File:** TIN and Office Field Codes are Fields 72 & 73 rather than 50 & 51.
- **HEW Software:** Not available until registration has taken place. Account Designees cannot access the software until they have been set up during the registration process by the Account Manager.
- **WEBSITE:** [www.cms.hhs.gov/MandatoryInsRep](http://www.cms.hhs.gov/MandatoryInsRep)

## What Employers Must Do:

- For all actions, consult with legal counsel and/or MSA Vendor
- See CMS User Guide (released 3/16/09).
- Section 7 to 8.2 (pages 18-26).
- Responsible Reporting Entities (RREs) have a window of 5/1/09 to 6/30/09 to register on the CMS secure website ([www.Section111.cms.hhs.gov](http://www.Section111.cms.hhs.gov)).
- RREs must appoint an Authorized Representative, who is empowered to execute contracts for the RRE.
- The RRE will perform the initial registration on the CMSSW. The Authorized Rep must designate an Account Manager.
- Each RRE ID# can have only one Account Manager, but RRES can obtain multiple ID numbers.
- The Account Mgr may be an employee of the RRE or agent. The AM may choose to manage the entire account and data file exchange, or may invite other company employees or data processing agents to assist.
- The AM may identify an Account Designee. ADs assist the AM with the reporting process. There is no limit to the number of ADs associated with one RRE ID.
- Typically the claims handling entity will generate the quarterly reports. They can be pointed in any direction; to a third party aggregator, directly to CMS (COBC), or back to the RRE (assuming the RRE is not an insurance carrier or entity with its own claims department).

Efficiency 1.3 Million We have the a  
With years of experience, you can trust in us. With years of experien  
Understanding Risk you can trust in us.  
Our focus is on creating programs customized to meet your unique needs. Understanding

May 1, 2009

# Thank you!

Additional contact options for questions:

Your Avizent Account Executive  
[Education@avizentrisk.com](mailto:Education@avizentrisk.com)

Jennifer Harrell  
Avizent  
Manager, Training and Development  
[jharrell@avizentrisk.com](mailto:jharrell@avizentrisk.com)  
800.777.4283 x25555

#### About Avizent

Avizent is one of the fastest growing national risk management providers of claims management, medical managed care, self-insured groups, alternative risk financing and RMIS software. The company has 40 locations and employs nearly 800 associates throughout the United States. For additional information, visit the Avizent website at [www.avizentrisk.com](http://www.avizentrisk.com) or call 888-646-9675.



AVIZENT | Understand Risk