

Mandatory Medicare Reporting Requirements Imposed by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007

As the Federal Government looks to finance its proposed reform of the U.S. healthcare system, the Medicare program is opening an unprecedented dialogue with liability carriers and self-insured entities. Through its implementation of a new reporting system mandated by Congress, Medicare will soon require self-insured entities to report claims payments they make to Medicare beneficiaries for personal injuries. These reports will alert Medicare to opportunities to recover Medicare “overpayments” from self-insured entities that failed to meet their obligations under federal law to pay first for those medical services.

Background

Medicare is the U.S. Government health insurance program that primarily covers U.S. citizens aged 65 and over. Benefits also are provided to some disabled individuals and to those with end-stage renal disease. Under the Medicare Secondary Payer (MSP) statute and regulations, it is well settled that Medicare almost always bears secondary liability for the medical claims of Medicare beneficiaries, while private group health plans, liability insurers, self-insured entities, no-fault insurers, and workers' compensation insurers must accept primary liability. In other words, Medicare can insist that these entities pay first for medical expenses where coverage overlaps, and thus limit Medicare's obligation to any shortfall.ⁱ

The Centers for Medicare & Medicaid Services (CMS), the federal agency within the Department of Health and Human Services (HHS) that administers the Medicare Program, is the largest payer of medical claims in the United States. Under the mandate of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA or the Act), CMS will require liability insurers (which CMS defines to include self-insured entities), no-fault insurers, and workers' compensation insurersⁱⁱ to electronically report certain claims information to CMS on a quarterly basis, in a form and manner specified by the Secretary of HHS.ⁱⁱⁱ The claims reported to CMS must involve an injured or deceased party, who is or was a Medicare beneficiary, for which the insurer or self-insured entity accepted responsibility for payment of bodily injury damages or medical items or services on or after January 1, 2010, or had an ongoing payment responsibility for medical items or services on or after July 1, 2009. Following a phased-in and now delayed implementation schedule, insurers and self-insured entities will begin reporting actual data sometime during the second quarter of 2010.

The Act also establishes reporting requirements for Group Health Plans (GHPs) or their insurers. Many GHPs have been voluntarily reporting similar claims information to CMS for years under contractual arrangements, but the significance of the Act for these GHPs is that reporting is now

mandated by statute, and stiff penalties attach for non-compliance. In contrast, the significance of the Act for liability insurers and self-insured entities (non GHPs) is that the Act extends broad reporting obligations and monetary penalties to them for the first time. This group of non-GHPs may well encounter difficulties collecting some of the required claims data that they historically have not received, and may not have a contractual right to demand, from a claimant with whom they do not stand in privity of contract (as does a GHP). Despite these challenges, CMS is betting that the penalties will motivate compliance. Failure to comply with the new reporting obligations could subject an RRE to a civil money penalty of \$1,000 for *each day* of noncompliance for *each individual* for whom it should have submitted information.

CMS will use the reported claims information to ensure that Medicare is not the primary payer on claims for Medicare covered items and services for which insurers, benefit plans, or other entities have the responsibility to pay as the “primary payer” under the MSP statute and MSP regulations. This MSP law establishes Medicare in most situations as a secondary payer to “liability” insurers, which, by CMS definition, include any AEGIS member retaining liability up to a retention amount (thus a “self-insured entity” under MSP law). While the MSP statute was originally enacted in 1980, CMS generally has had neither the claims information nor the financial resources necessary these past thirty years to pursue liability insurers that did not pay primary. Before the enactment of Section 111, liability insurers and self-insured entities had no obligation to report claims data to CMS unless they became aware that Medicare had made a primary payment for healthcare services or supplies that they had the legal obligation to pay.^{iv} Section 111 now offers CMS additional means by which it may obtain a broader set of claims information from which it can identify “Medicare secondary payer situations,” that is, instances in which CMS should pay (or should have paid) secondary. The federal deficit, the escalating costs of the Medicare program, and the effort to fund expansion of healthcare entitlements provide strong incentives for aggressive government enforcement of the Section 111 requirements.

In this article we (1) explain why members indemnified by AEGIS are required to report under Section 111 and (2) identify who can report on behalf of AEGIS members, what data must be reported, how it should be reported, and the implementation schedule and milestones for coming into compliance with the new requirements. The article also addresses the long-standing legal provisions that hold self-insured entities liable for Medicare overpayments. Finally, we reference CMS’s implementation guidance, a necessary resource for Information Services personnel responsible for establishing the data collection/reporting systems mandated by Section 111.^v

I. Why Are AEGIS Members Required To Report Under Section 111?

Section 111 requires “applicable plans” to report certain claims data to CMS as described in Section III below.^{vi} Applicable plans include “liability, self-insured, no-fault, and workers’ compensation plans.”^{vii} CMS refers to the entities that must report on behalf of these plans as non-GHP Responsible Reporting Entities (RREs).

CMS has clarified in its Section 111 guidance that “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.” CMS, LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS’ COMPENSATION USER GUIDE Appendix G, 19 (2009) (CMS USER GUIDE); *see also* 42 C.F.R. § 411.50. An AEGIS member that bears its own risk up to a retention limit will meet the CMS definition of a self-insured entity with a self-insured plan.

Many, if not all, AEGIS members will meet the definition of an RRE, which then obligates them to report certain claims data to CMS under Section 111.^{viii} As RREs, these AEGIS members must register with CMS on the “Coordination of Benefits Secure Website” (COBSW) and receive one or more RRE IDs (e.g., a member may request a separate ID for each line of business, subsidiary, or benefit plan, but may not register as an RRE for a sister company). They may not shift their reporting responsibilities to other entities—by contract or otherwise, and they remain solely responsible and accountable for complying with the Section 111 requirements and for the accuracy of their submitted data. AEGIS members may, however, appoint agents (including third party administrators, data service companies, and consultants) for the purpose of administering their Section 111 reporting processes and submitting RRE reports—if they designate these agents during the registration process; agents cannot designate themselves. CMS maintains no list of approved agents. Complete instructions for registration and agent designation are available in the CMS User Guide.^{ix} An updated version of the CMS User Guide is due to be released around the end of July 2009.

AEGIS members are the RRE as well for any payments made to a claimant above the retention limit. As RREs, AEGIS members are required to report claims data on the full claims paid amount even if AEGIS reimburses them for an amount paid over the retention limit. AEGIS itself does not have this reporting responsibility under Section 111 because it falls into an RRE exception for certain excess liability insurers. CMS guidance states that the key to determining whether Section 111 reporting is required by an excess insurer is whether the insurer’s payment is made directly to the injured claimant or whether the insurer reimburses the self-insured entity. “Where payment is being made to reimburse the self-insured entity, the self-insured entity is the RRE for purposes of the payment to the injured individual and no reporting is required by the insurer reimbursing the self-insured entity.” CMS USER GUIDE at 19. According to this definition, excess insurers who reimburse self-insured entities for claims paid above a retention amount are not RREs for any portion of the payment amount.

II. What Information Must AEGIS Members Report?

When Is The Section 111 Reporting Obligation Triggered?

An RRE must report claims data in two situations referred to by CMS as: (1) Total Payment Obligation To Claimant (TPOC), and (2) Ongoing Responsibility for Medicals (ORM).

Under TPOC reporting, an RRE must report to CMS the total remuneration it owes to an injured Medicare beneficiary on all claims resolved (fully or partially) through a settlement, judgment, award, or other payment *on or after* January 1, 2010.

ORM reporting requires the RRE to send data on all claims for which it had responsibility, *as of* July 1, 2009 or commencing anytime thereafter, for making ongoing payments for medical items or services provided to a Medicare beneficiary.^x

In other words, for claims involving a “single payment obligation” (a certain fixed sum)—regardless of how the payout is actually structured—with no separate assumption of ongoing responsibility for medicals, a report is only required if the settlement, judgment, award, or “other payment date” is on or after January 1, 2010.^{xi} Where the assumption of ongoing responsibility for medicals occurred prior to July 1, 2009, and continued on or after July 1, 2009, or began after July 1, 2009, reporting is required.

RREs also should keep in mind the following CMS guidance when determining whether to report certain claims payments:

- First, if an individual is not a Medicare beneficiary at the time the RRE assumes payment responsibility for ongoing medical services, the RRE must monitor the status of that individual and report when the individual becomes a Medicare beneficiary unless payment responsibility has terminated by that date.
- Second, even if an RRE advises CMS about a pending claim *before* the date of a settlement, judgment, or award, the RRE must again report the claim under Section 111 after the claim resolution. Prior notice is not a substitute for compliance with Section 111.
- Third, reporting is required regardless of whether underlying liability for medical services or bodily injury has been expressly determined or accepted provided there has been a settlement or judgment award.
- And finally, during a public CMS-led conference call, CMS has confirmed that Section 111 does not require insurers to create Medicare Set Aside Arrangements (MSAs). Transcript of CMS Town Hall Teleconference at 50 (Dec. 11, 2008).

Has CMS Established Claims Thresholds That Reduce An RRE’s Reporting Burden?

To limit the number of *de minimus* claims reported, CMS recently approved two categories of reporting thresholds for claims paid by self-insured plans and liability insurers: one for ORM and a second for TPOC.

- **Thresholds for Ongoing Responsibility for Medicals (“ORM”):** Self-insured plans have no *de minimus* dollar threshold for claims under this category, which means their RREs must report all claims accepting any responsibility for payment of covered medical services for Medicare beneficiaries.
- **Thresholds for Total Payment Obligation to the Claimant (“TPOC”):** Self-insured plans have **no** TPOC reporting requirements during the periods outlined below for the specified dollar ranges:

INTERIM PERIOD	TPOC AMOUNT	REPORTING EXEMPTION
Jan. 1, 2010 – Dec. 31, 2010	\$0 – \$5,000	Full
Jan. 1, 2011 – Dec. 31, 2011	\$0 – \$2,000	Full
Jan. 1, 2012 – Dec. 31, 2012	\$0 – \$ 600	Full

Where there are multiple TPOC claims reported by an RRE on one record (a record being both beneficiary and policy specific), then the combined TPOC must be considered in determining whether or not the TPOC amount has been exceeded. For TPOC claims involving a deductible (or retention amount), where the RRE is responsible for reporting both the deductible and any amount paid above the deductible (or any amount paid below or above a retention amount) (*e.g.*, the typical AEGIS member), the threshold applies to the total of these two figures.

CMS has established these thresholds solely for Section 111 reporting responsibilities. They do not provide a “safe harbor” with respect to any other Medicare Secondary Payer obligation. Moreover, CMS considers these limits interim thresholds and reserves the right to amend them through proper notice.

What Specific Claims Data Must RREs Report?

Section 111 requires submission of data by an RRE to CMS that is necessary for the agency to appropriately identify primary payers. Accordingly, if an RRE determines that the injured party is or was a Medicare beneficiary and is entitled to Medicare benefits, and the claim falls within a Section 111 dollar threshold, the RRE must initially report over 100 data fields for each claim, including information specified by the Secretary of HHS to enable an appropriate determination concerning coordination of benefits, including information regarding:

- Injured party (RREs or their agents must implement a procedure in their claims resolution process to determine whether the tort claimant is a Medicare beneficiary. They must submit either the claimant's Medicare health insurance claim number (HICN) or, if it is not available, the Social Security Number (SSN). How an RRE can compel a claimant to share this data when the claimant has no contractual obligation to do so, and is an adversary of the RRE and the insured, is an open question.)
- Claimant (if not the injured party)
- Plan insurance type (type of insurance coverage or line of business provided by the plan policy or self-insurance)
- Policyholder
- Attorney for claimant or injured party
- Incident and
- Resolution (including how resolved (ORM or TPOC) and for what amount)

The most critical data point sought by CMS under Section 111 reporting is whether the injured party is or was a Medicare beneficiary. To find out the Medicare status of an individual, RREs or their agents may submit queries to the Medicare Coordination of Benefits Contractor (COBC), the CMS contractor designated to handle all technical aspects of reporting and management of RRE submissions. An RRE may submit Query Input Files once per calendar month per RRE ID, and there is no specific submission timeframe. The COBC will respond to these queries within fourteen days. For the COBC to determine whether the individual listed in the Query Input File is a Medicare beneficiary, an RRE must provide either the HICN or the SSN. Many RREs are finding this requirement to be a challenge to meet because historically they have not collected this information and tort claimants often are reluctant or refuse to disclose their HICNs or SSNs to an adversary or due to identity theft concerns.^{xii} To assist these RREs, CMS has posted a memorandum on its website that explains to Medicare beneficiaries that RREs are required under Medicare law to collect SSNs and HICNs. In addition, CMS has stated in a town hall style teleconference open to the public that the Agency is in the process of developing model language that non-GHPs may use to solicit SSNs and other necessary data from a Medicare beneficiary, advising that the use of this exact language would provide a Section 111 "safe harbor" and effectively protect non-GHPs against Section 111 penalties. CMS TRANSCRIPT 61-62 (May 14, 2009).

To assist RREs in submitting queries, the COBC will supply, at no charge, HIPAA eligibility wrapper software (HEW) that contains a file format for electronic submission of Medicare queries. It is important to note that RREs with a large claims volume need not determine, or submit a query to

determine, the Medicare eligibility for each claimant 65 years and older; instead, these RREs may report claims data for each individual in the Medicare age bracket, thus shifting the burden to CMS to determine whose data is of interest to the agency.

To date, CMS guidance has not specifically addressed what reporting will be required from RREs involved in mass torts litigation (or even clarified who serves as an RRE). These types of catastrophic claims raise many Section 111 issues for RREs, including: (1) how to determine whether Medicare beneficiaries are involved when individual claimant data may not be in the RRE's possession; (2) what efforts CMS may require from RREs to obtain beneficiary information not in their possession; and (3) how, or if, insurers who contribute to a group settlement of a mass torts class action must apportion settlement funds to individual claimants when, for example, such funds may be put in escrow or paid out as a lump sum, without allocation to any individual claimant's medical expenses. During the July 14, 2009 town hall teleconference, CMS announced that interested parties may advise CMS by email of their desire to join the mass torts working group that CMS has formed to address these and other issues.

III. When Must RREs Begin Reporting And How Must They Report?

RREs, or their agents, will submit their initial claims data to CMS sometime during the second quarter of 2010, as instructed by the COBC. Thereafter, RREs will report claims data on a quarterly (calendar year) basis, during a seven-day submission period also assigned by the COBC. The date of the settlement, judgment, or award for each claim is the date that triggers the RRE's reporting obligation. If an RRE has accepted ongoing responsibility for medical payments on a claim, the RRE must report at least two events for each claim – when payment responsibility is assumed and when responsibility is terminated. RREs also must report if and when there are pertinent updates, corrections, or deletions to be made to a previously submitted record. The RRE is not to submit a report every time a payment is made.

All claim reporting must be submitted through an electronic file exchange, and each Claim Input File may only be submitted once within a quarter. The Claim Input File is the data set transmitted from an RRE to the COBC. Data records sent to the COBC as part of a Claim Input File are submitted on a beneficiary-by-beneficiary basis, by type of insurance, by policy number, etc. For example, if there is an automobile accident and the two involved drivers are insured by the same company and, under each driver's policy, the insurance company pays the same Medicare beneficiary who was injured in the accident, the insurance company would need to submit two records to the COBC. Additional examples of proper record submissions may be found in the CMS USER GUIDE.^{xiii}

Each RRE must register for and obtain an assigned RRE ID for every Claim Input File it will submit on a quarterly basis. As stated earlier, there is no limit to the number of IDs an RRE may obtain, and an RRE may continue to register for and request additional IDs after the initial registration. Because an RRE is permitted to submit a particular claims file only once per quarter, an RRE may need to

register for multiple ID numbers. For example, if an RRE operates two different claims systems, one that processes no-fault claims and another that processes workers' compensation claims, it may be difficult for the RRE to combine the reports of these systems in order to submit a single claims file to CMS. Accordingly, the RRE could register for two RRE IDs, one ID for the no-fault claims system and one ID for the workers' compensation system, and submit two claims files each quarter. RRE IDs may not be created solely to submit Query Input Files, and an RRE must submit a quarterly claims file for every RRE ID it establishes.

IV. Coming Into Compliance: The Timeline

To implement the Section 111 reporting requirements for non-GHPs, CMS has designed an implementation timetable that is comprised of five phases.

Phase 1: Development Period (Prior to Registration)

RREs will develop a system for collecting the data CMS requires for each claim. CMS will supply the Internet connection and file layouts for RRE data transmission to the COBC. RREs (or their agents) can choose to submit data via the Coordination of Benefits Secure Website (COBSW) using Hypertext Transfer Protocol over Secure Socket Layer (HTTPS) or Secure File Transfer Protocol (SFTP), or for large amounts of data, via Connect: Direct via the AT&T Global Network System (AGNS). CMS is providing free computer-based training.

RREs may dial in to the remaining, currently scheduled, CMS town hall teleconferences on August 11, August 18, September 8, and September 30 to ask questions regarding specific implementation concerns. The teleconferences have been held at least monthly since last fall, and written transcripts of all are posted on the CMS website.^{xiv}

Phase 2: Registration Period (May 1, 2009 – September 30, 2009)

RREs will register on-line by logging on to a secure website with the COBC. As explained earlier, an RRE must complete the registration process directly; it may not do so through an agent. Once the RRE submits its application via the secure website, CMS will begin working with the entity to set up the data reporting and response process.

Phase 3: Testing Period For Query Input Files (July 1, 2009)

The Query Function became available July 1, 2009 for an RRE that has completed registration and is in testing status, which means that the COBC has received the RRE's signed Profile Report. Both test and production Query Input Files will be accepted and processed for an RRE ID in testing status.

Although RREs have until September 30, 2009 to register, RREs cannot submit Query Input Files until they have completed registration and are in testing status for the applicable RRE ID(s).

CMS knows the file layout rules are complex. For this reason, the agency is assigning each RRE a COBC EDI representative. The "EDI Rep" will assist with the required test and production file exchanges.

Phase 4: Testing Period For Claim Input Files (January 1, 2010 – March 31, 2010)

CMS has moved the testing period for Claim Input Files back a quarter into 2010, although it appears that the agency may permit an RRE to begin testing in 2009 if it has successfully completed registration. Once testing is concluded for an RRE ID, the system will set the RRE ID to production status. Additional test files will continue to be accepted and processed after production status has been attained until actual reporting begins.

RREs that complete testing during the first quarter of 2010 *may* submit their first live production files during that quarter. RREs are not required to submit these files, however, until the second quarter of 2010.

Insurers may, but are not required to, use actual data to test their reporting systems. Manufactured (or dummy) data can be used to determine whether or not the submission and response files are transmitted and received without issue.

Phase 5: Initial Production Of Claim Input File Submissions Due (April 1, 2010 – June 30, 2010)

All RREs must begin their quarterly production reporting no later than the file submission timeframe assigned to each RRE ID by CMS.^{xv}

V. Sanctions For Noncompliance

Section 111 provides steep fines for noncompliance. Failure to comply with the reporting obligations could subject RREs to a civil money penalty of \$1,000 *for each day* of noncompliance *for each individual* for whom they should have submitted information.

The precise parameters of an RRE's Section 111 reporting obligations continue to evolve for non-GHPs, in part because CMS is far less familiar with non-GHP claims than with GHP claims. Given that CMS has acknowledged it is still working to define process-type reporting details, and that the agency has stated publicly it is primarily interested in making sure RREs comply with Section 111 and *not* in collecting penalties, we would expect that CMS would take into consideration an RRE's diligent

efforts to come into regulatory compliance before pursuing an enforcement action. To that end, we recommend that an RRE document its efforts to implement reporting processes and procedures and to test data transmissions with CMS. CMS's initial enforcement actions are likely to focus on those RREs who fail to register, implement a reporting system, and/or transmit data files.

VI. Potential AEGIS Member Liability For Medicare Overpayments

CMS's collection of claims data undoubtedly will lead to CMS recovery actions against self-insured entities for Medicare overpayments. Under the foundational principles of the MSP program introduced above, Medicare has a statutory right to receive direct recovery of any medical payments it makes, conditionally or in error, on behalf of a Medicare beneficiary, from any entity that is (or was) required or responsible under the law for making the primary payment (that is, the plan must have a "responsibility to make payment with respect to such [medical] item or service"), or from the provider, beneficiary, or beneficiary's counsel that receives that entity's primary payment. In other words, by statute, Medicare generally holds the "secondary" payment position to all other forms of coverage for medical claims, and Medicare's right to recover these payments takes precedence over the claims of any other party.^{xvi} Self-insured entities, like AEGIS members, are among the entities identified under the Medicare statute that can assume the "primary" position to pay for medical items and services rendered to Medicare beneficiaries if their legal responsibility to make such payments is established.^{xvii} In addition to its direct right of recovery, CMS has subrogation rights that permit the agency to step into the shoes of a Medicare beneficiary and sue the primary payer against which the beneficiary has a claim.

Where more than one entity designated as a primary insurer by the Medicare statute has responsibility under the statute for paying the bodily injury claims of a Medicare beneficiary, and one of these primary payers pays only a portion of the claims, the medical provider still seeking total payment for services rendered to the Medicare beneficiary typically must first demand payment from the other primary insurers before turning to Medicare.^{xviii} Medicare will only pay the portion of the medical charges that remain unpaid after the other insurers have paid primary benefits.^{xix} In addition, even though insurance plans or contracts may specify that benefits paid under their provisions are secondary to any other source of payment, or may limit payment benefits until all other sources of health insurance are exhausted, Medicare does not make payment when insurance benefits are otherwise available to pay claims for bodily injury.^{xx}

These statutory principles mean that if an AEGIS member settles a Medicare beneficiary's claim for bodily injury, then the beneficiary must first satisfy his or her healthcare provider claims out of the settlement proceeds before submitting any remaining claims to Medicare regardless of whether there is an admission of liability. If Medicare has already paid those claims (because, for example, the AEGIS member and the Medicare beneficiary were in litigation for years), then Medicare has the right to bring an action against the beneficiary, beneficiary's counsel, provider, or AEGIS member to recoup any payments Medicare made to the provider, regardless of whether the member has already

released settlement funds to the Medicare beneficiary or paid the provider. The statute does not set any order of repayment liability among these entities and individuals; however, the regulations do instruct that CMS look first to the beneficiary or entity receiving payment from the primary payer for recovery. If CMS is not reimbursed by those parties, the primary payer is responsible for reimbursing CMS, “even though it has already reimbursed the other party.”^{xxi} This means that the AEGIS member may incur duplicative liability for the beneficiary’s medical costs. And if Medicare must take legal action to recover from the member, Medicare may recover twice the amount of Medicare’s overpayments, thus tripling the member’s liability.^{xxii}

Before CMS comes knocking, an AEGIS member may be required to give notice to CMS if it has knowledge, *or arguably should know*, that Medicare has made a primary payment for medical services for which an AEGIS member has the responsibility to pay.^{xxiii} The MSP Manual elaborates on this notice requirement (referred to as the Section 411.25 notice), stating that “when a liability insurer is obligated to make payment to an injured plaintiff who is age 65 or older, the insurer has reason to know of Medicare’s probable interest and to act to ascertain Medicare’s involvement.”^{xxiv} Although the MSP Manual does not specifically state that this presumption applies to self-insured plans, the Medicare regulations define a self-insured plan as a subset of the class of liability plans. It therefore can be expected that CMS would apply the presumption to an AEGIS member. And, although the applicable regulation states only that notice is required “if it is demonstrated to a primary payer that CMS has made a Medicare primary payment for services for which the primary payer has made or should have made primary payment,” an AEGIS member may well receive sufficient information during its collection of Section 111 data to learn of Medicare’s earlier payment. But in no case should an AEGIS member assume that its reporting under Section 111 is the equivalent of giving CMS notice that Medicare has made an overpayment.

Medicare may recover its overpayments from judgments, settlements, or awards without regard to how the resolution stipulates disbursement should be made.^{xxv} This recovery authority includes situations in which the judgment, settlement, or award does not expressly include damages for medical expenses. As CMS explains in the MSP Manual:

Since liability payments are usually based on the injured or deceased person’s medical expenses, liability payments are considered to have been made “with respect to” medical services related to the injury even when the settlement does not expressly include an amount for medical expenses. To the extent that Medicare has paid for such services, the law obligates Medicare to seek recovery of its payments.^{xxvi}

In summary, if a Medicare beneficiary has filed a claim for bodily injury with a self-insured entity, Medicare may seek recovery for overpayments from any resulting judgment, settlement, or award with the exception of a court-ordered payment for non-medical loss following a decision on the merits of the case.^{xxvii}

VII. Looking Ahead – Implications Of Section 111 Reporting

In addition to meeting the new reporting requirements, AEGIS members should take measures to protect their interests with respect to claims that may involve a Medicare beneficiary. Given that AEGIS members (as self-insured entities), unlike GHPs, have no privity with the individuals whose medical costs they may pay in a liability settlement, the application of the MSP law to them raises many questions that neither courts nor CMS has to date answered:

- To what extent can AEGIS members protect themselves by providing CMS with advance notice of potential settlements and obtaining an advance determination of any obligation to reimburse Medicare?
- What mechanisms, if any, exist in underlying tort actions to seek judicial determination of any reimbursement liability?
- Does the three-year statute of limitations for Medicare's recovery of "conditional payments" from primary payers apply to AEGIS members? Although the statute states that the three years runs from the date of medical service, does the three-year period commence on this date if CMS has no knowledge of the member's potential payment liability for the Medicare services?
- Do the MSP statute and implementing regulations preempt state laws regarding claims handling and prompt payment, and do those state laws apply to self-insured entities? State law in many jurisdictions requires prompt investigation and settlement of claims; moreover, in certain jurisdictions, an insurer that fails to settle a claim within policy limits may incur liabilities in excess of policy limits. But a liability insurer or self-insured entity that pays an underlying claimant without waiting to determine any potential reimbursement obligation to Medicare faces a serious risk of paying that sum a second time to Medicare. On the other hand, delays incurred while waiting for Medicare to announce the amount of its interest in any liability settlement may subject the payer to additional liability under state law.
- Do the MSP statute and implementing regulations preempt the collateral source rule, an evidentiary rule that prohibits the admission of evidence that the claimant's damages were or will be compensated from some source other than the damages awarded against the defendant? The MSP requirement that a self-insured entity reimburse Medicare for a Medicare beneficiary's medical costs is arguably in conflict with a tort system that fails to credit the self-insured entity with the payment it already made to that Medicare beneficiary.
- What constitutional constraints and defenses exist to protect AEGIS members from making duplicative payments? May the Government constitutionally impose upon self-insured entities the administrative burden of reporting extensive claims information to Medicare, including information that is not within their immediate possession and that must be obtained from underlying claimants

with whom they are not in privity and who have no legal obligation to provide the information to them? May the Government constitutionally impose duplicative reimbursement liabilities upon self-insured entities that have made payments to underlying claimants, but who never agreed to participate in the Medicare system or to provide any form of health insurance?

- Does the plain language of the MSP Statute reach liability insurers who are contractually obligated to pay “damages” on behalf of their insureds, but who have no obligation to pay the medical costs of the underlying claimants, and indeed no contractual relationship with the underlying claimants?

A full discussion of these issues is beyond the scope of this Alert, intended primarily to discuss the new Section 111 reporting requirements, but these issues are important to factor into a complete assessment of third party liability under the MSP laws.

VIII. Summary Of MSP Principles And Section 111 Reporting

- Medicare does not pay primary on claims for Medicare covered items and services for which liability insurers and self-insured entities have a legal responsibility to pay first under the Medicare Secondary Payer (MSP) statute.
- The Section 111 reporting requirements give CMS new means to identify MSP situations and recover Medicare overpayments from primary payers. These reporting requirements do not replace or eliminate existing obligations under MSP law for any primary payer.
- Stated another way, CMS will use the reported claims information to ensure that Medicare does not pay primary on claims for Medicare covered items and services for which other entities have the responsibility to pay first under MSP law.
- Medicare is entitled to take the total amount of settlement or judgment if Medicare’s conditional payment exceeds the amount of the settlement, or a court fails to make an express determination that a certain amount of the judgment is reserved for non-medical loss. Medicare cannot recover a greater amount (for example, up to a policy limit) if that limit exceeds the settlement amount.
- Self-insured entities qualify as Responsible Reporting Entities (RRE) with reporting obligations under Section 111.
 - AEGIS members have reporting obligations as RREs under Section 111 because they meet the Medicare definition of a self-insured entity.
 - An RRE may designate an agent to report to CMS on its behalf, but the RRE remains solely responsible for complying with the Section 111 reporting requirements and paying any resulting penalties.

- During a CMS-assigned 7-day period in the second quarter of 2010, an RRE must begin quarterly reporting of its:
 - Total Payment Obligation to the Claimant (TPOC) for *all* claims resolved (fully or partially) through a settlement, judgment, or award, *on or after January 1, 2010*, where the injured party is/was a Medicare beneficiary. Certain small dollar thresholds apply.
 - Ongoing Responsibility for Medicals (ORM), which includes claims where the RRE had responsibility, *as of or after July 1, 2009*, for making ongoing payments for medical items or services provided to a Medicare beneficiary. No dollar thresholds apply.

- Compliance Timetable

May 1, 2009 – September 30, 2009	RREs must register with the COBC.
July 1, 2009	RREs may begin sending test and production Query Input Files to the COBC. CMS will use Query Input Files to determine whether an individual is a Medicare beneficiary.
January 1, 2010 – March 31, 2010	RREs should begin testing Claim Input File transmissions to the COBC.
April 1, 2010 – June 30, 2010	RREs must submit their initial production of Claim Input Files to the COBC.

- Failure to comply with Section 111 reporting obligations could subject an RRE to civil money penalties of \$1,000 for each day of noncompliance, for each individual for whom the RRE should have submitted information.

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This Alert is designed to provide current information for AEGIS Members regarding important legal developments. The foregoing discussion is general information rather than specific legal advice. Because it is necessary to apply legal principles to specific facts, always consult your legal advisor before using this discussion as the basis for a specific action.

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FOOTNOTES

- i See 42 U.S.C. § 1395y(b) (Social Security Act § 1862(b)(2)(A)); 42 C.F.R. Part 411.
- ii Regrettably, the Act's terminology—such as the defined phrases "self-insurance" and "no-fault insurance"—does not always align perfectly with the common usage in the liability insurance context and, therefore, it can appear awkward or cause confusion. Accordingly, individuals attempting to understand their obligations under the Act should focus on the Act's defined terms rather than how such terms are commonly used in the liability insurance context.
- iii CMS is the agency within HHS that is responsible for administering Medicare, Medicaid, SCHIP (State Children's Health Insurance Program), and several other health-related programs.
- iv See 42 C.F.R. § 411.25.
- v See http://www.cms.hhs.gov/MandatoryInsRep/01_Overview.asp#TopOfPage for additional overview information on the Section 111 reporting requirements.
- vi 42 U.S.C. § 1395y(b)(8).
- vii 42 U.S.C. § 1395(b)(8)(F); see also 42 C.F.R. § 411.50.
- viii 42 U.S.C. § 1395y(b)(8).
- ix See the CMS USER GUIDE <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf>.
- x See the CMS USER GUIDE <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf> for a complete explanation of each data element that must be reported to CMS.
- xi 42 U.S.C. § 1395y(b)(8)(C).
- xii This document is available at http://www.cms.hhs.gov/MandatoryInsRep/01_Overview.asp#TopOfPage.
- xiii See <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf>.
- xiv Prior non-GHP teleconferences were held on October 1, 2008, October 29, 2008, December 11, 2008, January 22, 2009, January 28, 2009, February 25, 2009, March 24, 2009, April 9, 2009, May 12, 2009, May 14, 2009, June 2, 2009, June 9, 2009, July 1, 2009, and July 14, 2009.
See http://www.cms.hhs.gov/MandatoryInsRep/07_NGHP_Transcripts.asp#TopOfPage to review the written transcripts of these calls.
- xv The most current Section 111 implementation timeline can be found on the CMS website at <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPV10UserGuide051109.pdf>.
- xvi 42 U.S.C. § 1395y(b)(2)(B)(ii).
- xvii *Id.* at § 1395y(b)(2)(A)(ii).
- xviii CMS Medicare Secondary Payer Manual (MSP Manual) Ch. 1 § 10.9 (A).
- xix *Id.* In some situations, a plan (e.g., a retirement plan) may be the tertiary payer to a liability insurer (the primary payer) and Medicare (the secondary payer). See MSP Manual Ch. 10 § 10.9.
- xx e.g., *id.* at Ch. 7 § 20.2.
- xxi 42 C.F.R. § 411.24(i); MSP Manual ch. 7 § 50.5.4.
- xxii See 42 C.F.R. §§ 411.22; 411.24(i); MSP Manual Ch. 7 § 50.5.3.
- xxiii 42 C.F.R. § 411.25.
- xxiv MSP Manual Ch. 7 § 50.5.3.
- xxv *Id.* at § 50.4.4.
- xxvi *Id.*
- xxvii *Id.* at § 50.5.