A Timely Analysis of Legal Developments

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New Medicare Secondary Payer Reporting Obligations for Workers' Compensation Plans

By John M. Cerilli and Ryan W. Green

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At a time where Medicare is massively under-funded, a new reporting requirement set to take effect on July 1, 2009, will significantly increase Medicare's ability to identify situations in which Medicare is paying for medical expenses that should be borne by so-called "primary payers," including workers' compensation plans.[1] By statute, Medicare is a "secondary payer" with respect to medical expenses associated with workplace injuries. As such, if Medicare pays medical expenses on behalf of a Medicare beneficiary who is injured in a work-related accident, Medicare is entitled to reimbursement from the responsible party or insurance carrier for that expenditure. When Medicare makes such payments, the payments are considered to be conditionally paid expenses subject to recovery.

In order to both reduce the amount of medical expenses paid on behalf of Medicare beneficiaries that are properly payable by an employer or insurance carrier and to more completely recapture conditionally paid expenses via the statutory subrogation claim process, Congress amended the Medicare laws to impose a mandatory reporting obligation on workers' compensation plans. The amendments leave the procedure for pursuing subrogation claims unchanged.

Coordination of Benefits (COB) Process

The Coordination of Benefits (COB) process is administered by the Coordination of Benefits Contractor (COBC). The COBC is a division of the Centers for Medicare and Medicaid Services (CMS), which is an agency housed within the Department of Health and Human Services (HHS). The COB process exists to identify any available insurance or self-insurance fund covering a Medicare beneficiary that may be responsible for

paying for medical expenses before Medicare becomes involved. In short, the COBC is tasked with identifying and stacking as much available insurance coverage as possible between the Medicare beneficiary and the Treasury. The purpose of the new reporting requirements is to aid CMS in improving the COB process.

To illustrate, assume that a Medicare beneficiary is involved in an automobile accident in her own vehicle, caused by an underinsured third party who also happened to be operating a defectively repaired car and the accident occurred during the course and scope of employment. In that instance, Medicare could be called upon to pay medical expenses on behalf of the injured worker without or before becoming aware of the circumstances of the accident. In this example, many potential primary payers are involved, such as the employer, if it is self-insured for workers' compensation purposes, or its workers' compensation and general liability insurance carriers, the employee's auto insurance carrier, the other driver's auto insurance carrier and the vehicle repair facility's general liability carrier. The new reporting requirements are designed to identify as many of these primary payers as possible in order to relieve Medicare's burden as a secondary payer of the injured individual's medical benefits.

Medicare, Medicaid, and SCHIP Extension Act of 2007

When Congress enacted the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), it set a timetable that requires workers' compensation plan compliance beginning July 1, 2009. The new reporting obligations, contained in section 111(8)(a) of the Medicare Secondary Payer Statute (MSP)[2] are as follows.

> (A) This section requires that an applicable plan (*i.e.* workers' compensation carrier or self-insured employer) 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 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.
>
> (B) The information described in this subparagraph is the identity of the claimant for which the determination under subparagraph (A) was made and such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

The statute itself simply delegates to HHS the responsibility for developing the reporting requirements with respect to timing, contents and form. The most striking feature of the amendment is the rather punitive penalty provision.

> (E) An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of **$1,000 for each day of noncompliance with respect to each claimant**. . . . A civil money penalty under this clause shall be **in addition to any other penalties** prescribed by law **and in addition to any Medicare secondary payer claim** under this subchapter with respect to an individual.

The cost of failing to report one Medicare beneficiary according to this statute is approximately $365,000 on an annualized basis. Failure to report just three Medicare beneficiaries for an entire calendar year has a price tag of more than $1,000,000. As drafted, the fines are imposed on a strict liability basis and do not presently require any willfulness in the failure to report as a basis for imposition of the same.

Moreover, it seems that the fine may be disproportionate to the per claim cost of medical expenses. As employers and insurers well know, it is not unusual for accidents resulting in soft-tissue injuries, for example, to linger as open cases accruing only modest medical expenses without any indemnity (i.e. wage loss) claim for permanent injury. It is inevitable that there will be many cases in which Medicare is never called upon to pay any medical expenses, but a company will nonetheless be subjected to huge fines for failing to report a Medicare beneficiary. In such cases, the disproportionate nature of the fine is all the more pronounced. For employers that are self-insured for workers' compensation purposes, beginning July 1, 2009, this will become a significant source of organizational financial risk. The punitive nature of these fines for noncompliance demonstrates rather convincingly that Congress is highly motivated to bring down the cost of administering Medicare benefits.

Who is a Responsible Reporting Entity or "RRE"?

Self-insured employers, insurance carriers and other entities meeting the definition of Responsible Reporting Entity ("RRE") are required to submit, on a quarterly basis, information of work-related injury claims involving Medicare beneficiaries. Only RRE's are required to comply with the new reporting requirements, and CMS has issued some guidance on how to determine whether an entity is an RRE.[3]

Insured Employer

According to CMS, where the applicable workers' compensation law or plan authorizes an employer to purchase insurance from an insurance carrier and the employer does so, the insurance carrier is the RRE.

Self-Insured Employer

Where the applicable law or plan authorizes an employer to self-insure and the employer does so independently of other employers, the self-insuring employer is the RRE.

Deductible Employer

Where an entity is self-insured for a high deductible, but payment is ultimately made through the insurer, then the insurer is the RRE for reporting purposes.

Third-Party Administrators

Third-Party Administrators (TPA) are never an RRE for reporting purposes.

TPA – Deductible Combination

An interesting scenario arises where an employer carrying a high deductible uses a TPA to administer and pay claims. In such a situation, instead of the insurance carrier, a TPA not subject to RRE reporting may be administering the claims. Based upon current guidance, in this instance, the *employer* is the RRE for reporting purposes. This result may catch many employers off guard and may prove to be a trap for employers who unknowingly fail to comply with the new rules.

Self-Insurance Trusts or Pools

According to CMS, where the applicable law or plan authorizes employers to join with other employers in self-insurance pools (*e.g.*, joint powers authorities) and the self-insurance pool is a separate legal entity with full responsibility to resolve and pay claims using pool funds without involvement of the participating employer, the self-insurance pool is the RRE. Moreover, where the applicable law or plan authorizes employers to join with other employers in self-insurance pools but any of the above delineated requirements are not satisfied, the participating employer is the RRE.

State Agency/Funds

Where the applicable law or plan establishes a state/federal agency with sole responsibility to resolve and pay claims, the established agency is the RRE. Where the applicable law or plan authorizes employers to self-insure or to purchase insurance from an insurance carrier and also establishes a state/federal agency to assume responsibility for situations where the employer fails to obtain insurance or to properly self-insure, if the state/federal agency itself resolves and pays the claims using state/federal funds or funds obtained from others for this purpose, the established agency is the RRE. In the event that the established state/federal agency designates an authorized insurance carrier to resolve and pay the claim using state/federal-provided funds without state/federal agency review and/or approval, then the designated carrier is the RRE. Finally, if such state/federal agency designates an authorized insurance carrier to resolve and pay the claim using state/federal-provided funds but state/federal agency retains review or approval authority, the state/federal agency is the RRE.

Use of Agents

According to CMS, RRE's are permitted to use agents for the reporting process. However, it is clear that the ultimate responsibility for the Section 111 mandatory reporting remains always with the RRE. Agents do not register with COBC and cannot be designated as Authorized Representatives of the RRE. Additionally, COBC does not communicate with the agent, but rather with the RRE regarding Medicare recovery.

What Claims Must Be Reported?

RRE's must report all claims that involve a Medicare beneficiary where, on or after July 1, 2009, there is a settlement, judgment, award or other payment that constitutes payment or reimbursement for medical costs. By implication, not every workplace injury involving a Medicare beneficiary needs to be reported. Indeed there are many reportable workplace accidents that involve very minor injuries that do not require medical treatment beyond first aid and, therefore, do not result in the payment of medical benefits. Furthermore, all claims involving ongoing responsibility for medicals (ORM) where that responsibility will extend beyond July 1, 2009, must be reported without regard to the date that obligation was assumed. However, recognizing that RRE's will need additional time to compile data relative to such claims, CMS has provided an extension of time to report ORM situations until the third quarter (July to October), of calendar year 2010. Moreover, RRE's are required to submit a subsequent report indicating ORM termination.

Registration and Testing

From May 1, 2009, through June 30, 2009, the RRE registration window will be open. RRE's must register before testing begins. The registration process involves the identification and assignment of certain responsibilities. First, the RRE must select an Authorized Representative with the legal authority to bind the organization to both contracts and the terms and conditions of MMSEA Section 111 reporting requirements. This individual has the ultimate accountability on behalf of the RRE and is required to be an RRE employee, but he or she cannot also act as an Authorized Representative. Second, the RRE must select and assign an Account Manager, separate from the Authorized Representative, whose responsibility it is to control the administrative process and manage the overall reporting process. This individual need not be an RRE employee, as the reporting process may be outsourced to an agent. Finally, the Account Manager may invite Account Designees to upload, monitor and transfer files.

Beginning July 1, 2009, and continuing through December 31, 2009, the testing phase will take place. All reporting will be accomplished electronically, and during this time RRE's will have the opportunity to test data collection, uploading and transmission as well as Query Input Files (discussed below). Production of live data is **not** required during the testing phase, and no penalties will be imposed for noncompliance.

Finally, beginning January 1, 2010, the first quarter of live reporting will commence. Thereafter, reporting will be completed on a quarterly basis. COBC will assign each RRE a seven-day file submission window for each quarter. It is recommended that the file submission be made on the first day of the submission window, as the timeliness of the submission will be measured based upon COBC batch processing. For example, a quarterly report submitted just minutes before the end of the seven-day window may not be processed before the window closes, resulting in an untimely report.

How Do You Know If an Injured Employee Is a Medicare Beneficiary?

As part of the new Section 111 reporting process, CMS has included a component known as the Query Process whereby RRE's can assess whether or not a claimant is also a Medicare beneficiary. This process acts as an important tool for both the RRE and CMS, the latter seeking to avoid a situation where RRE's simply submit information for every claim in order to avoid any penalties. Query Input Files may be submitted as often as once per month per RRE ID once live production begins. By submitting such a file, which includes

limited information about the claimant, COBC will determine whether the submitted information matches any records for a Medicare beneficiary. If so, then the RRE will report the required information for that claimant. If the response from COBC indicates the claimant is not a Medicare beneficiary, then no report is required regarding that individual. It remains to be seen whether or not the use of this tool will act as a safe harbor from any fines in the case of mistakes.

Practical Steps

The greatest risk faced by an RRE now, only one month from the opening of the registration window and just three months from testing, is failing to recognize that it is an RRE. The first and most important step every entity should take that has not otherwise confirmed its status as an RRE, is to make that assessment. This is particularly important for those employers carrying co-pays and deductibles administered through a TPA as well as for self-insured employers. These entities are particularly vulnerable to compliance failures. If the employer determines that it is not an RRE, it should immediately consult with its workers' compensation carrier, self-insurance trust or pool or appropriate state agency to confirm that such other entities understand their reporting obligations. In the case of any question or disagreement about which entity is the RRE, counsel should be sought immediately.

Second, once an entity identifies itself as an RRE, there is still time to develop a plan, prepare for registration and select an agent if the reporting requirement will be outsourced. Any agreement with an agent should have an enforceable and robust indemnity clause since the RRE maintains the ultimate responsibility for compliance. If the reporting is outsourced, the employer/RRE should develop a compliance program for oversight of the agent's practices. The potential liabilities are so significant that regular review of the reporting process must be planned.

Third, RRE's should develop clear procedures for checking whether a claimant is a Medicare beneficiary and for determining when the RRE must check for such status, such as when any medical expenses are paid or when there is a settlement that arguably could be, even in part, construed as payment for medical expenses.

John M. Cerilli is a Shareholder in Littler Mendelson's Pittsburgh office. Ryan W. Green is an Associate in Littler Mendelson's Northwest Arkansas office. If you would like further information, please contact your Littler attorney at 1.888.Littler, info@littler.com, Mr. Cerilli at jcerilli@littler.com, or Mr. Green at rgreen@littler.com.

[1] Liability Insurance and no-fault insurance is also included.

[2] 42 U.S.C. §1395y.

[3] User Guide, MMSEA Section 111 Medicare Secondary Payer mandatory Reporting – Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation; Version 1.0 (Mar. 16, 2009).