wiley

ALERT

Section 111 Bulletin: Congress Passes Long-Awaited Reforms To The Medicare Secondary Payer Recovery Process, Including Elimination Of SSN Reporting, But Built-In Regulatory Delays Could Postpone Insurer Relief

January 4, 2013

Both the Senate and the House have passed year-end legislation amending the Medicare Secondary Payer (MSP) statute and reforming the process by which liability and no-fault insurers and the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), coordinate payment for health care expenses incurred by Medicare beneficiaries. The Senate passed H.R. 1845, the Medicare IVIG Access Act, on December 21, 2012, two days after the bill passed in the House of Representatives. The legislation incorporates the provisions of H.R. 1063, the Strengthening Medicare and Repaying Taxpayers (SMART) Act previously passed by the House. The legislation was presented to the President on December 31, 2012. Because the 112th Congress has adjourned, the President must sign the legislation within 10 days of presentation (excluding Sundays) if it is to become law.

This legislation responds, in part, to complaints from the insurance industry that focus on the administrative delays insurers have experienced in obtaining "conditional payment" amounts from CMS before settling claims with Medicare beneficiaries. Although the basic Section 111 reporting process mandated by the Medicare, Medicaid, & SCHIP Extension Act of 2007 (MMSEA) will remain unchanged by the new legislation, the legislation is expected to eliminate certain procedural roadblocks to claims settlements and payments. If signed

Authors

Kathryn Bucher
Partner
202.719.7530
kbucher@wiley.law

Practice Areas

Health Care

Insurance

Section 111 Insurer Reporting and MSP Reimbursement

by the President, the law would require HHS to:

1. provide Medicare beneficiaries and authorized insurers with a definitive conditional payment amount within a set timeframe before settlement;
2. establish a process through which Medicare beneficiaries can dispute the conditional payment amount;
3. attempt to eliminate the required submission of Social Security Numbers (SSNs) or Health Insurance Claim Numbers (HICNs) as part of Section 111 reporting;
4. clarify that the $1,000 per day per claimant penalties are discretionary rather than mandatory; and
5. recognize a three-year statute of limitations governing MSP recovery and penalty actions.

HHS Must Provide Conditional Payment Amounts Within A Defined Timeframe

Perhaps most significantly, the new law, if it is signed by the President, will provide a definitive timeframe (called a "protected period") within which HHS must provide Medicare beneficiaries and insurance carriers with the conditional payment reimbursement amount owed to HHS or, otherwise, forfeit the government's reimbursement rights. HHS will be required to maintain a website that offers Medicare beneficiaries, their representatives, and authorized insurance carriers access to certain Medicare claims information. More specifically, beginning 120 days prior to the reasonably expected date of a settlement, judgment, award, or other payment resolving a Medicare beneficiary's claim for bodily injury or emotional distress, beneficiaries and insurers will be able to provide HHS with notice of the anticipated resolution of the claim and the expected date of a payment from the insured, insurer, or self-insured entity to the Medicare beneficiary.

Following provision of such notice, HHS will have 65 days to respond with a final conditional payment amount. This 65-day period may be extended for a period of an additional 30 days if the Secretary of HHS determines that additional time is required to address claims for which payment has been made. Once finalized, the conditional payment amount will be available to beneficiaries, their representatives, and authorized insurance carriers through an MSP website maintained by HHS. A statement of reimbursement amount downloaded after HHS's 65-day response period (or extended 95-day response period) shall constitute the final conditional amount subject to recovery by HHS, provided that the statement is downloaded within 120 days of the initial notice to HHS and within three business days of the date of the settlement, judgment, award, or other payment.

New Processes Would Resolve Discrepancies In Conditional Payment Amounts

Currently, the MSP statute imposes no timeframe on CMS's resolution of a Medicare beneficiary's challenge to a conditional payment reimbursement demand. Under the new legislation, if a Medicare beneficiary or his or her representative believes the reimbursement amount obtained through the online portal is incorrect, HHS must determine whether there is a reasonable basis to include or remove identified claims on the statement of reimbursement within 11 business days of the Medicare beneficiary or representative providing documentation that explains the discrepancy and offering a resolution. If HHS fails to make such a

determination within the requisite time period, the Medicare beneficiary's resolution shall be deemed accepted. HHS is required to promulgate final regulations to carry out this discrepancy resolution process within nine months of the effective date of the legislation. HHS also is required to promulgate regulations establishing a right of appeal and an appeals process for conditional payment reimbursement demands.

Legislation Clarifies Penalties Are Discretionary Not Mandatory

The legislation also clarifies that the $1,000 per day per claimant penalties for noncompliance with Section 111 are not mandatory by changing the statutory language from "shall be subject to a civil monetary penalty" to "may be subject" to such a penalty. *See* 42 U.S.C. § 1395y(b)(8)(E)(i). HHS is required to publish a notice in the Federal Register within 60 days of the effective date of the legislation that solicits proposals on the imposition of penalties. The legislation references the solicitation of proposals preventing the imposition of penalties where Responsible Reporting Entities (RREs) undertake good faith efforts to identify Medicare beneficiaries, but the legislation does not require that HHS actually implement safe harbors. These safe harbors would be valuable to RREs that continue to struggle with the unwillingness of some claimants to provide the required personal information necessary for Section 111 querying and reporting.

Legislation Would Eliminate Required Reporting Of SSNs And HICNs

H.R. 1845 requires HHS to modify the Section 111 reporting requirements within 18 months of the effective date of this legislation so that RREs are not required to report Medicare beneficiaries' SSNs and HICNs. Unfortunately, HHS is permitted to delay implementation of a revised process by multiple periods of up to one year each if the Department notifies the House and Senate that the modification threatens patient privacy or the integrity of the MSP program. Such a notice to the House and Senate is required to include the anticipated implementation date for the required modification. Given the Department's past unwillingness to embrace alternatives to the use of SSNs and HICNs, we anticipate that HHS will use this delay mechanism to avoid modifying the reporting process for the foreseeable future. The Department has represented on numerous occasions that it must have a beneficiary's SSN or HICN in order to process insurer reports and match claimants to Medicare enrollees in the current Medicare database that stores beneficiary eligibility and claims information, known as the Common Working File. The database cannot identify accurately a Medicare beneficiary through presentation alone of an individual's name, date of birth, and gender. Absent an appropriation to fund what may be an expensive and time consuming redesign of the Common Working File maintained by Medicare contractors at nine host sites around the country, we anticipate that the Department will argue that eliminating the requirement for SSNs and HICNs would prevent reliable identification of Medicare beneficiaries and frustrate the purpose of the MSP statute and Section 111 mandatory insurer reporting.

Legislation Clarifies Three-Year Statute Of Limitations

The new legislation clears up prior uncertainty over the statute of limitations governing MSP recovery actions by adding a provision to the MSP statute stating that "an action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than three years after

the date of the receipt of notice of a settlement, judgment, award, or other payment." The legislation clarifies that this statute of limitations also applies to penalties imposed by the Agency. Notably, the new statute of limitations is not retroactive; it applies only to actions brought on or after six months from the effective date of the legislation.

Annual Reporting Threshold Must Not Exceed Collection Costs

The legislation also requires HHS to establish a single annual threshold Section 111 reporting amount such that the average amount collected by Medicare will at least equal, if not exceed, the average cost of collection. HHS must make annual reports to Congress on the collection costs and identify the applicable threshold for the following year.

Legislation Still Leaves Issues Unresolved

This legislation, if signed by the President, will significantly reform the MSP recovery process and may facilitate a more timely settlement process for many Medicare beneficiaries and insurance carriers that does not expose carriers to the risk of double or triple payment of conditional payment amounts. It does not, however, address all outstanding MSP and Section 111 issues previously identified by insurers and presented to the Department. For example, HHS has yet to clarify how RREs are to report their individual shares of claims payments in mass tort and class action cases where the class is not closed at the time of settlement and/or claimant identities or individual payor amounts allocated to individual claimants are not known. Also, because Congress did not revise the MSP statute to permit class action or trust fund administrators to act as RREs, HHS is unlikely to determine it has the delegated authority to do so and arguably would not choose to restrict its collection authority. In sum, because the legislation sets out a series of new regulations that the Department must implement and will require HHS to enter into new administrative contracts or amend existing contracts to meet the new requirements, these and other unresolved issues may continue to sit on the back burner.

Our Section 111 Team routinely covers the Section 111 NGHP Teleconferences held by CMS, and we send periodic Alerts to our clients addressing notable Town Hall discussions and other Section 111 developments. We also maintain a searchable electronic database of Town Hall transcripts back to October 2008. Please let us know if you would like more information about any of the Section 111 topics discussed in this Alert. You also may access our Section 111 webpage and other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.