

Mandatory Insurer Reporting: Waiting for the Other Shoe to Fall

By Chris Gullen

“Mandatory Insurer Reporting” is the phrase being used by The Centers for Medicare and Medicaid Services (CMS) to refer to new requirements imposed by the Medicare, Medicaid and SCHIP Extension Act of 2007 passed by Congress in December 2007 and signed by President Bush on December 30, 2007.

This stealth legislation took all of 11 days to go from introduction in Congress to signature by the President. Why? Its proponents believe it will generate billions of dollars in new federal revenue without raising taxes. Where will those billions of dollars come from? Insurers, self-insureds and injury claimants.

The law requires all group health, workers' compensation, liability and no fault insurers and self-insureds to:

- Determine if any individuals making claims against them are recipients of Medicare, Medicaid or SCHIP benefits, and
- If so, to report certain information to CMS once the claim is resolved through settlement, judgment, award or other payment (regardless of whether or not there is a determination or admission of liability.)

Severe financial penalties are promised for those who do not comply with the new requirements.

The purpose of the new law is to allow CMS to more readily enforce its rights as a secondary payer of medical expenses against those insurers and self-insureds. It will also allow CMS to enforce its right to reimbursement of past conditional payments. The usual target of those reimbursement demands by the government: Medicare beneficiaries themselves. However, federal law allows CMS to seek reimbursement from insurers and self-insured as well as the Medicare beneficiaries.¹

The reporting requirements are effective in July 2009, but insurers and self-insured companies nationwide are scrambling to determine what they need to do to comply with the law. Most companies will need to modify existing software used in handling workers comp, liability, no fault and group health claims to allow them to identify claimants who qualify for the applicable federal benefits and to assist in reporting the required claim data to CMS.

Show Me the Money

As the man said, its all about the money. The Medicare Program had 44 million beneficiaries and paid out \$432 billion in 2007.² The Medicare trustees have warned Congress that payouts continue to increase at a rate alarmingly greater than revenues will support, and increased revenue to support the plan is badly needed.

Playing Hot Potato

Medicare has something in common with insurance and self-insurance plans covering group health, liability, no fault and workers' compensation risks. Each pays medical expenses. And many of those plans have beneficiaries in common.

When my Aunt Eleanor was injured in an automobile accident, she was in the course of her employment. She was also on Medicare, had a no fault automobile policy and a group health policy. The guy who ran the red light and hit her car had a liability insurance policy.

Aunt Eleanor's medical expenses from the accident could potentially be paid by any one of 5 "insurance plans" including Medicare. Ideally, those 5 plans would get together, figure out which of them should cover the medical expenses and pay up. In the real world, 4 of those plans did in fact pay a portion of those medical costs, including Medicare.

She was a hot potato, and nobody wanted to hold onto her claim for long. Some initial medical care was taken care of by



the insurers but as her condition worsened and costs increased, some of the insurers bailed out and began denying requests for payment. She was tossed from one insurer to the other. Finally, Medicare stepped in and covered much of the treatment.

Its Good to be Secondary

Those payments by Medicare for my dear aunt's care are called "conditional payments" – payments made by Medicare where a "primary payer" has an obligation to pay but does not. Under federal law³ group health, liability, workers' compensation and no fault insurance and self-insurance plans are "primary" to Medicare. In other words, those plans are supposed to pay first. Medicare only pays if no insurance or self-insurance plan is obligated to pay the medical expense.

If Medicare makes a conditional payment and it turns out that one or more insurance or self-insurance plans was obligated to make the payment, Medicare can not only recover the money from the primary plan or plans, it can recover twice the amount of the payment, plus interest.⁴

In for a Penny, In for a Pound

Determining whether a particular insurance plan is obligated to pay medical expenses in a specific case is not always easy. Sometimes factual and legal issues arise that raise doubt about the duty to pay. Even where liability is in grave doubt, a claims adjuster may decide to settle a case for less than full value without admit-

ting liability to avoid the possibility of ultimately owing the whole thing or to avoid the cost of defending the claim.

In Aunt Eleanor's case, there was a dispute over whether she was truly in the course and scope of her employment when the accident occurred. If the workers' compensation claim had been accepted by the workers' compensation insurer, Eleanor's medical expenses related to the accident would have been covered for her remaining lifetime. Because of the questionable liability, the claim was settled with a lump sum payment. After the settlement, Eleanor's medical expenses related to the accident were paid by Medicare.

But where that settlement means that Medicare will get stuck with paying medical expenses after the settlement is made, the insurance plan has a new problem. An insurance plan becomes primary to Medicare not just by accepting the claim or being found liable for it in an adjudication. An insurance plan becomes primary to Medicare by settling a claim, even with a denial of liability.⁵

Needle in a Haystack

In recent years CMS has taken serious steps to save money by finding cases where primary payers are liable. CMS has also beefed up its efforts to collect conditional payments from primary payers and Medicare beneficiaries who have received settlements from primary payers.

One problem in those money-saving efforts has been the difficulty of determining which Medicare beneficiaries are entitled to have insurance plans cover their medical expenses. There are literally thousands of insurance and self-insurance plans, each of which plan may have hundreds or thousands of open claims. Finding out about settlements made to Medicare beneficiaries by primary payers has also been a near-impossibility.

Among the overall hundreds of thousands of claims are claimants who are current Medicare beneficiaries. CMS wants to know which of its beneficiaries have pending injury claims, and which of its beneficiaries have received claim payments.

That will make the job of turning the payment obligation over to the primary plan much easier, and will certainly make the job of collecting reimbursement of conditional payments less of a burden.

What does this mean for the insurance and self-insurance plans? A lot more reporting to the feds, for sure. Ultimately, it means a lot more claims from CMS for reimbursement of conditional payments, and a reduced likelihood of liability for medical payments being transferred from insurers to Medicare.

Because of the "you are primary if you settle" rule, it may mean fewer nuisance settlements and fewer "med pay" plans -under which a claimant's emergency medical care may be covered regardless of a lack of liability.

Expansion of Medicare Set-Asides?

Under the Medicare Secondary Payer statute, the parties to injury claims involving Medicare beneficiaries have had an obligation to protect the interests of Medicare in the settlement of those claims. "Protect the interests of Medicare" in practice usually meant that the parties would determine if treatment for the injury was paid for by Medicare and, if so, Medicare's outlays would be reimbursed out of the settlement funds.

But that reimbursement only took care of past payments by Medicare. Once the settlement was completed, the injured party would often end up having continuing treatment for the injury covered by Medicare, with the primary payer/ insurance plan being off the hook.

In 2001 CMS adopted the position that - at least in workers' compensation cases- the parties' obligation to protect the interests of Medicare required them to not only reimburse past Medicare payments but also to earmark a portion of the settlement to payment of future medical expenses that otherwise would be payable by Medicare. Hence the birth of the infamous "Medicare set-aside."

Some believe that mandatory insurer reporting augers the expansion of

Medicare set-asides beyond the world of workers' compensation into group health, no fault and liability claims. So far CMS has been fairly tight lipped about that prospect.

What is certain is that - with mandatory insurer reporting- every participant in the filing, administration and settlement of injury claims will need to become familiar with the Medicare Secondary Payer statute and related regulations. CMS is hungry for money, and it will soon have the ability to find the pockets in which the cash is hiding.

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Chris served as Director of Risk Management for Kmart Corporation, responsible for the company's national insurance, safety, workers compensation and liability programs. He left Kmart in 2001 to begin a private practice as a settlement consultant, assisting insurance companies and large self-insured companies in resolving high exposure personal injury claims.

Since 2003 Chris has worked with The Tenon Group, and has provided Medicare set-aside services to attorneys, insurance companies, self-insured employers and monopolistic state funds. He can be reached at cgullen@tenon-group.com

- 1 42 C.F.R. § 411.24(g).
- 2 2008 Annual Report of the Board of Trustees.
- 3 42 U.S.C. § 1395y(b)(2)(B)(ii) - Medicare Secondary Payer statute.
- 4 42 C.F.R. § 411.21, 411.24(c)(2).
- 5 42 U.S.C. § 1395y(b)(2)(B)(ii).