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MEDICARE SECONDARY PAYER UPDATE – CMS DELAYS REPORTING DEADLINES

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In December 2007, Congress amended the Medicare Secondary Payer law (MSP) through Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA). The amendment imposes mandatory reporting obligations on Responsible Reporting Entities (RREs), including liability, self-insured, no-fault and workers' compensation insurers (collectively referred to as "non-Group Health Plans" or "Non-GHPs") regarding settlements with Medicare beneficiaries. On February 26, 2010, the Centers for Medicare & Medicaid Services (CMS) issued a new Non-GHP User Guide, providing updated guidance for complying with the MMSEA Section 111 requirements and announcing that reporting deadlines would be delayed.

Specifically, pursuant to Section 111 and under the new deadlines, a RRE must report claim information under both of the following circumstances:

- Where the injured party is a Medicare beneficiary and the claim is resolved (or partially resolved) through a settlement, judgment, award or other payment on or after October 1, 2010. Previously, settlements occurring on or after January 1, 2010 were to be reported.
- Where ongoing responsibility for medicals (ORM) related to a Medicare beneficiary's claim was assumed on or after January 1, 2010. In addition, reporting is required for claims where ORM exists on or through January 1, 2010, regardless of the date of the initial assumption of responsibility for ORM. Previously, the trigger date for reporting of claims involving ORM was July 1, 2009.

This mandatory reporting was designed to strengthen CMS' ability to enforce the MSP rules, which describe the specific circumstances under which Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary. Medicare is "secondary payer" in situations when a Medicare eligible individual has received a settlement, judgment award or other payment from a non-GHP that is intended to cover medical expenses that might otherwise be covered by Medicare. Non-GHPs subject to Section 111 reporting requirements have an affirmative duty to submit Medicare entitlement information to the CMS Coordination of Benefits Contractor on a quarterly basis.

These new reporting requirements are extensive and onerous and will require a significant expenditure of time and effort, particularly at the outset. Non-GHPs must report extensive information (e.g., over 100 data fields must be completed) about all settlements, awards or other payments made to Medicare beneficiaries on or after October 10, 2010, where *the date of incident occurred on or after December 5, 1980* (the date the liability and no-fault insurance MSP provisions became effective). Insurers will also have to gather information to determine the Medicare eligibility of claimants in lawsuits or other recovery actions asserted against them. The need to gather this information, which should done at the outset of any recovery action initiated against the insurer that includes a claim for bodily injury and/or illness, represents a significant change in litigation practice.

Cozen O'Connor has developed Section 111 Compliance Guidelines for Non-GHPs that detail the information that must be reported, how information is to be reported, and the impact of the reporting and other MSP requirements on settlements. We look forward to assisting and providing efficient guidance to any clients who may be subject to these new rules.