THE COMPLEXITY OF THE MANDATORY MEDICARE SECTION 111 REPORTING RULES AND ITS PRACTICAL LEGAL AFFECTS – IS THERE A BREAK IN SIGHT?

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I. INTRODUCTION

Medicare is a health insurance program for people age 65 or older, people under 65 with certain disabilities, and people of all ages with end-stage renal disease.[1] Medicare was originally considered a primary payer system because "the private health insurance industry made its coverage secondary to [M]edicare's."[2] As a result, at its inception, Medicare was considered "the 'secondary' payer only for medical services covered by workers' compensation, and the 'primary' payer for all other eligible medical services provided to eligible participants."[3] In response to the increasing financial burdens on the Medicare system and in an attempt to shift the burden of costs to private sources, Congress enacted a series of amendments to the Medicare provisions of the Social Security Act in 2007 which provided numerous circumstances under which Medicare was no longer a primary payer.[4] "Medicare Secondary Payer" (hereinafter "MSP")

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[1] Michael A. de Freitas, Annotation,*Validity, Constriction and Application of Medicare Secondary Payer Provisions of Social Security Act (42 U.S.C.A. § 1395y(b)) and Regulations Promulgated Thereunder*, 126 A.L.R. FED. 553 (1995).

[2] *Id.*

[3] Christopher S. Berdy & W. Steven Nichols, *The Medicare, Medicaid & SCHIP Extension Act of 2007: A Practitioner's Introduction to Resolving Personal Injury Liability. Claims by Medicare Beneficiaries*, 76 DEF. COUNS. J., Oct. 2009, at 393, 394.

[4] *See id.* §5; de Freitas, *supra* note 1; *See also* Sonja P. Morgan-Marshall, *Federal Medicare Secondary Payer Compliance and Now Mandatory Insurer Reporting – What's Next?*, TRIAL ADVOC. Q., Summer 2009, at 6 ("[M]edicare is not expected to pay for medical services as long as payment 'has been made, or can reasonably be expected to be made, promptly, under a workmen's compensation law or plan of the U.S. or under an automobile or liability insurance policy or plan (including self-insured plan) or under no-fault insurance").

is the term commonly used to refer to situations where the Medicare program does not have primary payment responsibility.[5] Today, Medicare is the "secondary" payer in two circumstances. First,

> Medicare is a secondary payer to [group health plans] for Medicare beneficiaries who are eligible Medicare beneficiaries . . . and who have [group health plan] coverage on the basis of their own or their spouse's current employment with an employer that has [at] least twenty employees for beneficiaries aged sixty-five or older, or at least 100 employees for the disabled, or have end stage Renal disease and who have [group health plan] coverage on any basis.[6]

Second, Medicare is a secondary payer where certain other forms of insurance are responsible for a Medicare-eligible individual's health care expenses.[7] In this context, Medicare is essentially secondary where an individual is treated for an injury or illness which is work-related, was caused by an accident, or where either a no-fault insurance or group health plan will cover such illness or injury.[8]

On December 29, 2007, President George W. Bush signed into law the Medicare, Medicaid and SCHIP Extension Act of 2007 (hereinafter "MMSEA").[9] Section 111 of MMSEA imposes onerous new reporting requirements on liability (including self-insurers), no-fault and worker's compensation insurers with respect to Medicare beneficiaries who have coverage under group health plan (hereinafter "GHP") arrangements, as well as for Medicare beneficiaries who receive settlements, judgments, or other awards or payments from liability insurance (including self-

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[5] CTRS. FOR MEDICARE & MEDICAID SERVS., MMSEA SECTION 111 MEDICARE SECONDARY PAYER MANDATORY REPORTING: LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS' COMPENSATION USER GUIDE, at 12 (2d ed.2009).

[6] Berdy & Nichols, *supra* note 3.

[7] *Id.* at 394-95 (citing 42 U.S.C. § 1395y(b)(2)(A)(ii) (2008); Memorandum from Ctrs. For Medicare & Medicaid Servs., Introduction to Section 111 Mandatory Medicare Secondary Payer Reporting. 1 (Feb. 23, 2009), *available at* http://www.cms.hhs.gov/MandatoryInsRep/Downloads/RevisedSection111022309.pdf.).

[8] Morgan-Marshall, *supra* note 4.

[9] Roy A. Franco et al., *Mission Impossible: Resolution of a Case with a Medicare Claimant?*, FOR THE DEF., May 2009, at 8.

insurance), no-fault insurance, or worker's compensation.[10] The passage of this new legislation reinforces the notion that the federal government is intent on ensuring that Medicare is always treated as the payer of last resort in these situations and is intended to provide Medicare with new and additional tools to enforce this right. Under the MMSEA, parties designated as "Responsible Reporting Entities" (hereinafter "RREs"), are required to report certain information to the Centers for Medicare and Medicaid Services (hereinafter "CMS").[11] In response to the enactment of the Section 111 reporting requirements, it is imperative that RREs and those parties who represent RREs in any capacity take significant and proactive steps to reasonably consider the interests of Medicare when resolving insurance claims involving current or future Medicare beneficiaries; of utmost importance is developing a thorough understanding of the Section 111 statutory scheme and how to comply with its tedious reporting requirements.[12]

The MMSEA is a complicated web which has just recently begun to be unraveled.[13] CMS has been presented many questions which, although the act was passed in 2007, remain without clear answers. As a result, the implementation date for the reporting requirements has been pushed back numerous times. The implementation date has already been delayed two full years from the initial January 1, 2009 date; RREs are currently expected to begin testing the reporting system on January 1, 2010 and to begin mandatory reporting in the first quarter of 2011.[14] The purpose of this Article is to provide detailed instructions on complying with the Section 111 registration requirements and to analyze the new reporting requirements and the significant issues they present for insurers and their attorneys and to present a variety of solutions which, if acted upon by the appropriate party or entity, will help ensure compliance with the requirements and prevent the imposition of severe penalties.

Section II discusses RREs in greater detail, particularly regarding who qualifies as an RRE. Additionally, it argues that one of the most onerous tasks faced by the insurance industry is determining if an

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[10] 42 U.S.C. §§ 1395y(b)(7)-(8) (2008).

[11] *Id.*

[12] *See* Berdy & Nichols, *supra* note 3, at 393-405.

[13] It is important to note that this body of law is continuously changing and developing. Indeed, from this paper's initial drafting through its publication CMS issued numerous updates and clarifications. As such, it is highly likely that after publication certain areas will be further developed.

[14] MMSEA 111 WHAT'S NEW, https://www.cms.gov/MandatoryInsRep/04_Whats_New.asp#TopOfPage (last visited October 4, 2010).

organization is or is not considered an RRE for Section 111 reporting purposes. This section outlines the importance of making this determination.

Section III briefly explains Medicare entitlement and eligibility and argues that RREs may have extreme difficulty in obtaining the information necessary to make a determination as to a claimant's Medicare beneficiary status. It concludes that RREs should make mandatory reporting of a claimant's social security number a prerequisite to receiving any settlement or other form of payment and/or that defense counsel should include requests for this information in interrogatories served on any plaintiff. However, this section also highlights the particular difficulties presented by "older" claims where some of the suggested solutions may be ineffective.

Section IV outlines the reporting process for RREs including registering with CMS and detailing what information must be submitted to CMS and when the information must be submitted. It argues that the use of agents for reporting purposes by RREs may provide an additional point of liability for the RRE and therefore concludes that RREs should not use agents as a means of attempting to comply with the Section 111 reporting requirements.

Section V discusses the penalties faced by RREs for non-compliance with the Section 111 reporting requirements. It argues that imposing heavy monetary fines for non-compliance, particularly in the scenario where a claimant has failed to provide the RRE with requested information is a violation of the Eighth Amendment's Excessive Fines Clause and is therefore unconstitutional. As a result, this section concludes that any penalties which may be imposed on an RRE should instead be shifted to the claimant and/or the claimant's attorney on a strong showing from the RRE that the claimant has failed to provide the information required by the RRE to ensure compliance with the Section 111 reporting requirements. Section V further suggests a process which RREs should use to ensure they have any information necessary to challenge any fines for non-compliance with the Section 111 reporting requirements.

Section VI presents a variety of solutions to the numerous problems presented by the Section 111 reporting requirements. In particular it discusses the development of errors and omissions policies to protect RREs from potential non-compliance; it suggests this solution as particularly useful to self-insureds. Second, it discusses and advocates the mandatory use of Medicare set aside arrangements, patterned after the current requirement for workers' compensation, for liability (including self-insurance) and no-fault insurers as an alternative method of protecting

Medicare's financial interests and to the strict reporting requirements advocated in the MMSEA.

II. RESPONSIBLE REPORTING ENTITIES

The first major issue posed by the MMSEA is determining who should be designated as an RRE. Section 111 requires only RREs to report information to CMS. Medicare holds the RRE solely responsible for the accurate and timely filing and reporting of claims and it is therefore critical to identify the proper RRE.

However, the process of identifying who qualifies as an RRE has proven difficult and confusing. For example, in the summer of 2009, ACE USA, a retail operating division of ACE Group, offering property, casualty, risk-management and accident and health insurance products through retail brokers, released information advising that its insureds would be the RRE for almost all policy types.[15] In October 2009, ACE USA released the following statement: "While we believe there is merit to the position that our insured could be properly designated as the RRE for claims against deductible liability policies, we recognize the information received from CMS can be interpreted in several ways."[16] Therefore, in the October 2009 release ACE USA assumed responsibility as the appropriate RRE.[17] These two press releases clearly show the ambiguities in Section 111 and the complications in interpreting its requirements.

A. GHP RREs

GHP RREs are generally insurers or third party administrators ("TPAs"). A TPA is an entity that pays and/or adjudicates claims and may perform other administrative services on behalf of the GHP, the plan or the plan insurers.[18] In instances where an insurer, an entity that, in return for the receipt of premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments, does not process GHP claims itself, but contracts with a TPA to

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[15] Press Release, ACE USA, Update Information: ACE and the Medicare, Medicaid & SCHIP Extension Act (Summer 2009) (on file with author).

[16] Press Release, ACE USA, Updated Information: ACE and the Medicare, Medicaid & SCHIP Extension Act (October 5, 2009).

[17] *Id.*

[18] *See* § 42 U.S.C. 1395y(b)(7) (2008).

perform such services, the TPA has the responsibility of reporting.[19] Employers are Section 111 RREs for GHP purposes under only very limited circumstances.

B. Liability Insurance (Including Self-Insurance) and No-Fault Insurance

For non-GHP purposes (liability insurance, self-insurance, no-fault insurance or workers' compensation), the RRE is the "applicable plan."[20] The term "applicable plan" means the "following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement: (i) [l]iability insurance (including self-insurance); (ii) [n]o fault insurance; (iii) [w]orkers' compensation laws or plans."[21] The Health Care Financing Administration (hereinafter "HCFA"), which administers Medicare, defines an applicable plan as "any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness."[22]

A non-GHP [RRE] is an employer or defendant's insurance carrier (i.e., workers' compensation insurer, general liability insurer, or no-fault insurer). For example, if an employer is self-insured for workers' compensation or liability insurance, the employer may be an RRE."[23] An insurance carrier may choose to handle claims processing on its own or to outsource these responsibilities to another entity. However, this distinction is irrelevant in relation to the determination of the RRE and an insurer is considered an RRE regardless of whether or not it handles its own claims processing.[24]

1. Liability Insurance

Liability insurance is defined in the regulations implementing the MMESA as

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[19] *Id.*

[20] CTRS. FOR MEDICARE & MEDICAID SERVS., INTRODUCTION TO SECTION 111 MANDATORY MEDICARE SECONDARY PAYER REPORTING (2009).

[21] 42 U.S.C. § 1395y(b)(8).

[22] 42 C.F.R. § 411.21 (2006).

[23] Berdy & Nichols, *supra* note 3 at 399; OLLIS & CO., SECTION 111 OF THE MEDICARE, MEDICAID AND SCHIP EXTENSION ACT OF 2007 (MMSEA), *available at* http://ollisinsurance.com/wp-content/uploads/2009/07/section_111.pdf.

[24] RRE Overview, http://www.piattconsulting.com/index.php?option=com_content&view=article&id=131&Itemid=91 (last visited Oct. 4, 2010).

> Insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property. . . . Liability insurance payment means a payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurance policy, by any individual or other entity that carries liability insurance or is covered by a self-insured plan.[25]

Essentially, liability insurance (including self-insurance) "is coverage that indemnifies or pays on behalf of the policyholder or self-insured entity against claims for negligence, inappropriate action, or inaction which results in injury to an individual or damage to property."[26] Liability insurance includes the following: homeowners' liability insurance, automobile liability insurance, product liability insurance, malpractice liability insurance, uninsured motorist liability insurance, underinsured motorist liability insurance, etc.[27]

2. Self-Insureds

In *Mason v. Am. Tobacco Co.*,[28] the United States District Court interpreted "self-insured plan" as used in the Medicare as Secondary Payer (hereinafter "MSP") statute as involving an "entity that has assumed posture similar to that of an insurance company."[29] The Code of Federal Regulations defines a self-insured plan as "a plan under which an individual, or private or governmental entity carries its own risk instead of taking out insurance with a carrier."[30] The Health Care Financing Administration has ruled that "the mere absence of insurance purchased from a carrier does not necessarily constitute a 'plan' of self-insurance."[31] In determining the defendants' status as possible "self-insured plans," the court in *Mason* stated that "one requirement for an entity to be a self-insured plan is 'the provider must establish a fund with an independent fiduciary which is documented by a written agreement that includes legal

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[25] 42 C.F.R. § 411.50 (2006).

[26] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 5.

[27] *Id.*

[28] Mason v. Am. Tobacco Co., 212 F. Supp. 2d 88, 91 (E.D.N.Y. 2002).

[29] *Id.*

[30] 42 C.F.R. § 411.50.

[31] Medicare as Secondary Payer and Medicare Recovery Against Third Parties, 54 Fed. Reg. 41716, 41727 (Oct. 11, 1989).

responsibilities and obligations required by State laws' for payment of medical expenses of those injured by its products."[32]

In a May 2010 alert issued by CMS, CMS stated that it will consider payments by sponsors of clinical trials for any injuries or complications arising out of clinical trials to be self-insurance; as such, the sponsors are considered to be RREs and must report these payments to CMS.[33] As early as 2004, CMS had maintained the position Medicare would not make payments in situations where the clinical trial sponsor agreed to cover payments not otherwise covered by another payer.[34] However, CMS, until May 2010, consistently failed to give clarification as to whether or not the sponsor's agreement to make such payments constituted a liability insurance plan.[35] As such, prior to that date, sponsors of clinical trials were unable to determine their status as RREs and begin the required registration process. In the event CMS had not further extended the initial reporting date, these sponsors would have faced severe penalties. This situation illustrates the ongoing difficulty in determining whether or not an entity has self-insurance and the problems that difficulty presents.

3. No-fault insurance

The regulations implementing MMSEA define no-fault insurance as

> Insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing

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[32] *Mason*, 212 F. Supp. 2d at 92 (quoting Mt. Diablo Med. Ctr. v. Blue Cross & Blue Shield Ass'n, Dec. No. 96-D40, 1996 WL 862610, at *6 (P.R.R.B. July 1, 1996)).

[33] Memorandum from Ctrs. For Medicare & Medicaid Servs., ALERT: Clinical Trials & Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation (May 6, 2010), *available at* http://www.cms.gov/MandatoryInsRep/Downloads/AlertClinicalTrailsNGHP.pdf.

[34] Janice Ziegler et al., *CMS Issues Section 111 Alert in NGHP Context Regarding Clinical Trials*, MONDAQ, June 17, 2010, http://www.mondaq.com/unitedstates/article.asp?article_id=103200.

[35] *Id.*

the accident. This insurance includes but is not limited to automobile, homeowner's, and commercial plans.[36]

No-fault insurance is essentially a plan of "insurance that pays for health care services resulting from injury to an individual or damage to property in an accident, regardless of who is at fault for causing the accident."[37]

III. MEDICARE ENTITLEMENT, ELIGIBILITY AND ENROLLMENT

As mentioned above Medicare, is a federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people of all ages with end-stage renal disease.[38] It is distinguishable from Medicaid, which consists of state run health insurance programs designed to provide health insurance to low income pregnant women, children under the age of 19, people 65 and older, people who are blind, people who are disabled and people who need nursing home care.[39] It is possible to qualify for both Medicare and Medicaid; however, the Section 111 reporting requirements concern only Medicare beneficiaries.[40]

Medicare is comprised of two "parts." Medicare Part A, commonly referred to as "hospital insurance," helps a qualifying individual pay for inpatient care received in a hospital, skilled nursing facility, or hospice, and, if certain conditions are satisfied, home health care.[41] The second part, Medicare Part B, commonly referred to as "medical insurance" helps a qualifying individual pay for "medically-necessary doctors' services and other outpatient care."[42] Medicare Part B also pays for certain preventative services and services that may prevent an illness from progressing.[43]

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[36] 42 C.F.R. § 411.50 (2006).

[37] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 5, at 13.

[38] de Freitas, *supra* note 1, at § 2a.

[39] DEP'T OF HEALTH AND HUMAN SERV., WHAT IS MEDICARE?, *available at* http://www.medicare.gov/Publications/Pubs/pdf/11306.pdf (last visited Oct. 4, 2010).

[40] *See id.*

[41] *Id.*

[42] *Id.*

[43] *Id.*; Medicare beneficiaries may also choose to enroll in Medicare Part D, which is Medicare's prescription drug coverage plan or in Medicare Part C, which are commonly referred to as "Medicare Advantage Plans."

A. DETERMINING A CLAIMANT'S MEDICARE BENEFICIARY STATUS

Another issue for RREs involves determining the Medicare beneficiary status of claimants. There are a variety of ways by which an RRE may determine a claimant's Medicare status. "An RRE can request that the claimant provide his or her Health Insurance Claim Number, which is the number on the claimant's Medicare card. RREs may also obtain a benefits statement from the Social Security Administration by searching through the CMS-developed 'Query System,' or by using the claimant's first and last names, Social Security Number, and Social Security Consent Form signed by the claimant."[44] In the alternative, rather than requesting a claimant provide the information necessary to perform a query check, an RRE may request the claimant provide information as to their Medicare beneficiary status.[45]

Each method for determining a claimant's Medicare beneficiary status poses serious problems and highlights significant obstacles for RREs. First, if the RRE requests the claimant provide it with information as to its Medicare beneficiary status or social security number (hereinafter "SSN") and other information, the RRE may not always be able to rely on the truthfulness or completeness of the claimant's response to the RRE's request.[46] For their part, claimants may decide to withhold that information. CMS has provided space on the forms to be used by RREs in requesting a claimant's Health Insurance Claim Number (hereinafter "HICN") and SSN for a claimant to "explain the reason(s) for refusal to provide requested information"; this indicates CMS's awareness that claimants may choose not to provide crucial information to RREs.[47] Furthermore, an alert issued by CMS merely advises potential claimants that it is appropriate for an RRE to request their SSN and/or HICN; unfortunately for RREs, the alert does not advise or require compliance with any such requests.[48] In order for the Coordination of Benefits

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[44] Berdy & Nichols, *supra* note 3, at 399.

[45] Kenneth R. Meyer & Genevieve M. Spires, *Beware of Added Complications in Claims Involving Medicare Beneficiaries*, NEW JERSEY L. J. Sept. 28, 2009 at 2.

[46] *See id.*

[47] Richard L. McConnel, et. al, *No Port in a Storm? Crucial Safe Harbor Still in Doubt Under New Medicare Section 111 Reporting Requirements*, INS. COVERAGE 4, Dec. 4, 2009, at 3, 5.

[48] Press Release, Collection of Medicare Health Insurance Claim Numbers (HICNs), Social Security Numbers (SSNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers) – ALERT (April 6, 2010).

Contractor (hereinafter "COBC") to make a determination as to a claimant's Medicare beneficiary status it must be able to exactly match either a Health Insurance Claim Number or SSN exactly and match at least three of the four remaining criteria (first initial of the first name, first 6 characters of the last name, date of birth and gender) exactly.[49] A claimant who refuses to provide the requested information to an RRE therefore makes it impossible for both the RRE and the COBC to make a determination of the claimant's Medicare beneficiary status. As a result, a claimant who refuses to provide the requested information makes it impossible for an RRE to comply with the Section 111 reporting requirements.

An alternative method to obtaining beneficiary status includes submitting "a query to CMS' Coordination of Benefits Contractor to determine whether a claimant is a Medicare beneficiary."[50] An RRE should perform regular query checks through the "Query System" for every claimant in an attempt to determine Medicare beneficiary status; this includes performing a check at the inception of the claim and prior to any settlement or payment. It is particularly important to perform multiple query checks on claimants who were initially identified as not being eligible Medicare beneficiaries because such a claimant's status may change over the course of processing the claim. The information required to complete such an inquiry include: the claimant's date of birth, SSN and sex of the claimant.[51] Therefore, completing an investigation into a claimant's Medicare status will likely involve the need to obtain the claimant's Social Security Number (hereinafter "SSN").[52] However, non-health group plans cannot compel a claimant to provide such information and as noted above, in other instances the claimant may simply refuse to provide this information.[53] Also, as noted above RREs cannot rely on claimant's to receive honest or complete answers to requests for this information. In a town hall teleconference held on October 22, 2009 CMS advised insurers that a "claimant who is a Medicare beneficiary would have an obligation to provide their HICN or SSN to the insurer, but that a claimant who is not a Medicare beneficiary would not be obligated to

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[49] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 5, at 35.

[50] McConnel et al., *supra* note 47.

[51] *Id.*

[52] Joe Herbers, *Medicare Data Requirements to Boost Workers Compensation Costs*, PINNACLE NEWS, July 2009, at 1-2.

[53] *Id.*; Kevin Quinley, *Baring its Teeth*, CLAIMS MAGAZINE, Oct. 6, 2009.

respond," though it is unclear what statutory or regulatory authority supports this assertion.[54]

A solution to this problem is for claims handlers to include a condition to their settlements which requires "that the claimant (or claimant's attorney) provide the Social Security number to enable the settling party to comply with MMSEA."[55] Where a claimant commences a lawsuit against an RRE to obtain payment, defense counsel should, in their interrogatories, request the claimant reveal whether or not he or she is a Medicare beneficiary or when he or she expects to begin receiving Medicare benefits.[56] Defense counsel may also use interrogatories to "seek information about the plaintiff's Medicare Identification Number, when Medicare entitlement began, and whether any claim for the plaintiff's medical care related to the injuries alleged in the lawsuit have been paid by, or filed with, Medicare."[57] However, these methods may not be successful for an RRE's existing claims and therefore a retrospective process should be developed to gather the necessary data on existing claims. Specifically, RREs must develop procedures to claims where settlements have been reached but the RRE maintains ongoing responsibility for medicals, after July 1, 2009 and for lawsuits in which discovery has closed.

In response to these troubling issues some industry professional have advocated a "safe-harbor" provision that would apply to RREs that have attempted in good faith to obtain the necessary information from claimants but are unable to do so or are provided inaccurate information regarding whether a particular claimant is receiving Medicare.[58] It appears that CMS has adopted a limited "safe-harbor" provision.[59] In an alert

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[54] McConnel et al., *supra* note 47, at 5.

[55] Quinley, *supra* note 53.

[56] Sharon Caffrey et al, *Medicare Secondary Payer Statute: New Reporting Requirements for Products Liability and Toxic Torts Clients*, 198 N.J.L. J. 868 (2009).

[57] *Id.*at 869.

[58] McConnel, et al., *supra* note 47, at 3-4 (A "safe-harbor" makes sense in the context of liability insurers and self-insured entities that have no contractual relationship with the claimant, do not control the claimant's actions, and have no legally enforceable means for obtaining information from the claimant.); Franco, *supra* note 9, at 9.

[59] *See* Press Release, Ctrs. for Medicare & Medicaid Servs., CMS Alert: Compliance Guidance Regarding Obtaining Individual HICNs and/or SSNs for Non-Group Health Plan (NGHP) Reporting Under 42 U.S.C. § 1395y(b)(8) (Aug. 24, 2009). However, a note to the Alert reads: "This process does not provide a 'safe-harbor' to any reporting entity attempting to use it to avoid reporting MSP

published on its website, CMS advised that an RRE would be considered "compliant" if it has obtained a copy of the form used to request necessary information signed by the claimant.[60] This limited "safe-harbor" provision fails to address the scenario where an insured or self-insured transmits the necessary forms for requesting the required information to the claimant but the claimant fails or refuses to return the form. It is likely that many claimants will simply disregard the insured's or self-insured's request for the form because "claimants have little or no incentive to provide the requested information to liability insurers or self-insured entities, and in some circumstances, they arguably have an incentive *not* to make the disclosure."[61] This will undoubtedly leave RREs liable for unreported information which cannot possibly be obtained. CMS has indicated it may shift its "safe-harbor" position by expanding the protections for insurers and self-insured entities.[62] However, as CMS representatives have advised in their town hall teleconferences, the Liability Insurance (Including Self-Insurance), No-Fault Insurance and Workers' Compensation User Guide (hereinafter "User Guide") and other written alerts produced by CMS are the official source of information where discrepancies exist and as of the drafting of this paper those sources contain no expanded "safe-harbor" provision.

The safe-harbor provisions proposed by industry professionals pose a different problem, i.e., that such a provision undermines the intent of the Section 111 reporting requirements. The goal of Section 111 is to protect Medicare's future financial interests by ensuring that Medicare is, where appropriate, the secondary payer. A "safe-harbor" provision would allow certain claims to remain unchecked by the CMS system and therefore leaves open the possibility that Medicare will make unnecessary payments or will be ill-informed to collect reimbursements for past conditional payments. As discussed below a solution to this problem with the safe-harbor provision is to transfer the penalties to the party responsible for non-compliance.

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data about an individual known to the reporting entity to be a Medicare beneficiary." *Id.*

[60] *Id.*

[61] McConnel et al., *supra* note 47, at 4.

[62] *Id.* (In a town hall teleconference on September 30, 2009, CMS representatives appeared to depart from the written guidance contained in the alert and implied that the safe-harbor might extend more broadly if the insurer could prove it has a "process" in place to obtain information from claimants and that the request form was delivered to a specific claimant by certified mail or otherwise).

IV. REPORTING REQUIREMENTS

During the investigation of a liability claim, if the claimant is a Medicare beneficiary, the RRE must place the CMS COBC on notice of the loss.[63] "An RRE does not need approval from the Medicare beneficiary to make this notice."[64] "[T]he trigger to report involves whether there is an expectation of making a payment. If there is no liability and no expectation of making any type of payment, there is no duty to report."[65] Those required to report under MMSEA were required to commence collection of the data required for reporting prior to the testing of the reporting process which is scheduled to commence on January 1, 2011.[66]

A. REGISTERING WITH CMS

Any RRE who has an expectation of making payments to a claimant must register with CMS in order to comply with the Section 111 reporting requirements. As noted above, "[e]ntities who are RREs for purposes of the Section 111 liability insurance (including self-insurance), no-fault insurance, or workers' compensation are not required to register if they will have nothing to report."[67] CMS has an admittedly "hard" and "complicated" registration and reporting process for RRE's. Prior to commencing the registration process, RREs must determine how they will submit Section 111 files to the COBC and how many Section 111 Responsible Reporting Entity Identification Numbers (hereinafter "RRE ID") will be needed.[68] An RRE who wishes to use different agents to

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[63] *See* 42 C.F.R. § 411.25(a) (2010).

[64] *Id.*; 42 U.S.C. § 1395y(b)(8)(A)-(B) (2006).

[65] Franco, s*upra* note 9, at 10; Meyer & Spires, *supra* note 45.

[66] Alan Cooper, *Will New Law Require Set-Asides for Medicare in P.I. Cases?*, VA. LAW. WKLY, Nov. 23, 2009.

[67] Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 23 ("For example, if an entity is self-insured solely for the deductible portion of a liability insurance policy but it always pays any such deductible to its insurer, who then pays the claim, it may not have another to report. However, those who do not register initially because they have no expectation of having claims to report, must register in time to allow a full quarter for testing if they have future situations where they have a reasonable expectation of having to report.").

[68] Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 33 ("Only one Claim Input File may be submitted on a quarterly basis for each RRE ID. Due to corporate organization, claim system structures, data processing systems, data centers and agents that may be used for file submission, RREs may want to submit

submit workers' compensation claims and liability and no-fault claims must register twice to obtain two RRE IDs.[69] An RRE who establishes multiple RRE IDs must submit a quarterly Claim Input File for every RRE ID formed, regardless of whether or not they have any reportable claims for the reporting period.[70]

The registration process begins with the RRE entering the COB secure website and providing basic information about the RRE and its authorized representative.[71] The authorized representative is "the person who's able to essentially legally bind the RRE to [a contract and the terms and] requirements of the Section 111 reporting"; the authorized representative is generally a person at the executive level in the organization.[72] The authorized representative is the person responsible for, among other things, reporting, signing off on any information provided by the RRE during registration and signing off on who an RRE appoints as its account manager.[73] Essentially, the authorized representative has "ultimate accountability for the RRE's compliance with Section 111 reporting requirements."[74] Once CMS has received this information, a letter is mailed US Post to the authorized representative; the letter will contain a personal identification number (hereinafter "PIN").[75]

Once the authorized representative has received the PIN, he or she will provide that information to the account manager.[76] The account manager is the person who manages the day to day activities, including processing and account information.[77] The account manager may be an employee of the RRE or, if the RRE chooses, may be an agent assigned the reporting tasks.[78] The account manager must then return to the COB secure website to complete the account setup process. The account manager will be required to provide information about themselves, develop their own personal login ID and password, and set up the remainder of the RRE's

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more than one Claim Input File to the COBC on a quarterly basis and therefore will need more than one RRE ID in order to do so.").

[69] *Id.*

[70] *Id.*

[71] Telephone interview with Bill Decker, Pat Ambrose, Barbara Wright, and Bill Zavoina (Jan. 22, 2009).

[72] *Id.*

[73] *Id.*

[74] Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 31.

[75] Telephone interview with CMS (Jan. 22, 2009).

[76] *Id.*

[77] *Id.*

[78] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 5, at 24.

account information, which includes information relating to the agent that will be used in the file transfer.[79]

Once the account manager has completed the second step in the process, "the system will generate a profile report and issue that profile report to [the] authorized representative via email."[80] The authorized representative then reviews the information, signs the last page of the report and returns it to CMS.[81] Further, after account managers have completed their step in the registration process they have the ability to invite an unlimited number of individuals, both employees of the RRE and outside agents, to become account designees.[82] The account designees are individuals who assist the account manager with the reporting process they "are able to upload and transfer files, monitor file statistics and so on."[83]

RRE's were required to register with CMS by September 30, 2009, however the complications in determining who is considered an RRE has led to flexibility in this registration deadline.[84] The registration process for RREs will remain open indefinitely to allow for ongoing registration.[85] Practitioners recommend registering with CMS as soon possible because RREs are required to "test their abilit[ies] to upload files in early 2010"[86] and to begin making quarterly reports of all payments to all Medicare beneficiaries in January 2011. CMS advises allowing an entire quarter of testing prior to commencing mandatory reporting. Therefore, RREs who failed to register prior to January 1, 2010 are likely to face penalties for non-compliance. There is no exception to penalties for RREs who were required and able to register prior to that date, but simply failed to do so. RREs that are not prepared for the reporting process to begin face the possibility of being fined for unreported claims.[87]

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[79] Telephone interview with CMS (Jan. 22, 2009).

[80] *Id.*

[81] *Id.*

[82] *Id.*

[83] *Id.*

[84] Sharon Caffrey, et al., *Have you Registered Under MMSEA? New Reporting Obligations & Penalties for Medicare Secondary Payers*, MONDAQ (October 19, 2009).

[85] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 5, at 26.

[86] Caffrey, et al., *supra* note 84.

[87] *Id.*

1. Foreign RREs[88]

As late as October 22, 2009, nearly a month after the initial September 30, 2009 registration deadline, CMS had no registration process available for foreign RREs and no guidelines as to what steps these entities should take to ensure compliance with the Section 111 reporting requirements.[89] A foreign entity is "an entity that does not have a U.S. address and/or a U.S. Tax Identification Number (TIN) or Employer Identification Number (EIN)."[90] CMS initially advised these RREs "what [they] should do is wait."[91] On December 29, 2009, CMS finally released registration guidance for RREs who are foreign entities. Foreign RREs are advised by CMS to obtain a United States EIN by completing the Internal Revenue Service SS-4 application.[92] As a result of the late date at which CMS released this information foreign RREs were not required to register until April 1, 2010.[93] However, it is important to note that this delay in registration does not change the reporting requirements of foreign RREs; foreign entities are required to follow the same registration and reporting procedures as domestic RREs once they have obtained a U.S. EIN.[94] The delay was not anticipated to change the reporting date requirements associated with Ongoing Responsibility for Medicals or with 'Total Payment Obligation to Claimant' amounts.[95] Therefore, foreign RREs were expected to register at a later date than domestic RREs yet were required to

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[88] An interesting and yet unresolved legal issue surrounding foreign RREs is whether or not CMS may assert extraterritorial jurisdiction on these RREs who make direct claims payments to U.S. residents. *See* Federation of Regulatory Counsel, Inc., *Medicare Secondary Payer Reporting: Extraterritorial Applicability of Requirements to Foreign Insurers*, 21 FORC J. 2 (2010).

[89] Telephone interview with CMS (Oct. 22, 2009).

[90] Press Release, Ctrs. for Medicare & Medicaid Servs., Office of Financial Management/Financial Services Group, ALERT: Registration Guidance for Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation Responsible Reporting Entities (RREs) Who Are Foreign Entities (Dec. 29, 2009).

[91] Telephone interview with CMS (Oct. 22, 2009).

[92] *See* Press Release, Ctrs. for Medicare & Medicaid Servs., *supra* note 90.

[93] *Id.*

[94] *Id.*

[95] *Id.*

gather and prepare their information for reporting to begin on the same date as domestic RREs.

B. USE OF AGENTS FOR REPORTING PURPOSES

According to the CMS MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting: Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide (hereinafter "MMSEA User Guide"), agents are not RREs "for purposes of the MSP reporting responsibilities."[96] However, an RRE may "contract with an entity to act as an agent for reporting purposes."[97] The RRE is responsible for registering, reporting and filing and will designate the agent who will be reporting during the registration process.[98] It is important to note that an RRE may not shift its Section 111 reporting responsibility to its agent, whether the attempt to do so is by contract or otherwise. The RRE remains the party solely responsible and accountable for understanding of and compliance with the Section 111 requirements and for the accuracy of the data submitted.[99]

While it is likely numerous companies and organizations will form with the purpose of taking on the reporting responsibilities of RREs, it is not advisable to procure an agent to satisfy reporting requirements. The use of agents in the reporting process raises potential liability for the RRE because the RRE lacks control over the reporting process engaged in by the hired agent yet is still held responsible through monetary fines for any non-compliance with the reporting requirements. The RRE can ultimately be liable for any and all misdoings and errors made by the agent during the reporting process, a possibility that can be easily eliminated by an RRE retaining, rather than delegating the responsibility of reporting.

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[96] Ctrs For Medicare & Medicaid Servs., *supra* note 5, at 22 ("Agents may include, but are not limited to, data service companies, consulting companies or similar entities that can create and submit Section 111 files to the COBC on behalf of the RRE.").

[97] *Id.*

[98] *Id.*

[99] *Id.*

C. CLAIM THAT TRIGGERS A REPORTING REQUIREMENT AND REPORTING THRESHOLDS

Whether or not a claim triggers reporting requirements depends on the type of insurance in question. For liability lines of coverage, the reporting requirements are triggered by any kind of payment made on or after October 1, 2010 to a Medicare beneficiary for a claim or potential claim as a result of bodily or person injury, and/or ongoing responsibility for payment of medical services.[100] For worker's compensation and other Ongoing Responsibility for Medicals (ORM) payments, CMS requires a look back for ORMs paid from January 1, 2009, in which the file is closed by the insurer, but can be reopened if further medicals are submitted.[101]

Certain claims can be excluded from the mandatory Section 111 reporting requirements because they do not meet the CMS-established reporting thresholds. For liability insurance (including self insurance) and workers' compensation total payment obligation to the claimant (hereinafter "TPOC") the established thresholds are:

(a) For TPOCs dates of January 1, 2010 through December 31, 2010, TPOC amounts of $0.00 - $5,000.00 are exempt from reporting except as specified in (d) below.
(b) For TPOCs dates of January 1, 2011 through December 31, 2011, TPOC amounts of $0.00 - $2,000.00 are exempt from reporting except as specified in (d) below.
(c) For TPOCs dates of January 1, 2012 through December 31, 2012, TPOC amounts of $0.00 - $600.00 are exempt from reporting except as specified in (d) below.
(d) Where there are multiple TPOCs reported by the same RRE on the same record, the combined TPOC amounts must be considered in determining whether the reporting exception threshold is met.[102]

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[100] Press Release, MARSH & Am. Soc. For Healthcare Risk Mgmt., MMSEA Section 111 Non-Grp. Health Plan Liab. Ins. (including Self Ins.), No-Fault Insurance, and Workers' Comp. Frequently Asked Questions 2 (2009).

[101] *Id.*

[102] *Id.* at 5.

There are further situations where a case-by-case analysis must be made to determine whether or not an entity is considered an RRE and whether it must submit information on certain claims.[103] For example, in the context of reinsurance, stop loss insurance, excess insurance, umbrella insurance, guaranty funds and patient compensation funds which have some responsibility beyond a certain limit may be required to report claim in certain situations. "The key in determining whether or not reporting . . . is required for these situations is whether or not the payment is to the injured claimant/representative of the claimant vs. payment being made to the self-insured entity to reimburse the self-insured entity."[104] If the payment is made to the self-insured in the form of a reimbursement then the self-insured is the RRE. However, if the payment is made to the injured claimant or her representative then the insurer is the RRE for reporting purpose.[105] It is therefore advisable in these situations to make payments to a party other than the injured claimant or their representative. Development of such a policy prevents those entities named above from becoming RREs.

D. WHAT TO REPORT

Initial reports made to CMS must include "information for all claims involving a settlement, judgment, award or other payment made to a Medicare beneficiary" after July 1, 2009 for ORM and January 1, 2010 for TPOC.[106] "The Claim Input File is the data set transmitted from a MMSEA Section 111 RRE to the COBC that is used to report liability insurance (including self-insurance), no-fault insurance, and workers' compensation claim information where the injured party is a Medicare beneficiary and medicals are claimed and/or released or the settlement, judgment, award, or other payment has the effect of releasing medicals."[107] When making that report to the COBC, an RRE is required to obtain and report approximately 130 data points. These data fall into five distinct categories:

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[103] Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 75-78 (For example, a payment made specifically as a one-time payment for defense evaluation does not trigger the reporting requirement if made directly to the provider or other physician; "[w]here there is a settlement, judgment, award or other payment with no establishment/acceptance of responsibility for ongoing medicals, the RRE is not requirement to report, etc.").

[104] *Id.* at 75.

[105] *Id.*

[106] Meyer & Spires, *supra* note 45.

[107] Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 34.

(1) The Injured Party/Medicare beneficiary Information: Includes identification information, date of injury, cause of injury, venue, injury information, product identification and insurance/self-insurance claim and contact information
(2) Injured party attorney information []: includes detailed attorney contact information along with attorney/law firm TIN
(3) Settlement, Judgment, Award or Other payment information []: includes amounts and dates for ongoing responsibility for medical and total payment obligations
(4) Claimant information, if other than injured party []: includes contact information for estate or other claimant in survival or wrongful death actions.
(5) Claimant (other than injured party) attorney []: includes attorney contact information along with TIN.[108]

Once the data is transmitted in the form of a Claim Input File, COBC will use the file to determine whether or not a particular claimant is considered an eligible Medicare beneficiary by matching the information provided in the Claim Input File with already existing Medicare data.[109]

Initially, uncertainty surrounding reporting requirements existed where an RRE had a claim in which it has an ongoing responsibility for future medical requests, as of the implementation date, even where the claim had been closed in the RRE's records. In a January 2009 teleconference CMS indicated it was still looking at "how far back [it] will require [RREs] to go in terms of cases that are already closed" as of the implementation date.[110] It now appears CMS will require RRE's to report any claims where an ongoing responsibility exists as of July 1, 2009, regardless of when the RRE initially settled the claim.[111] This will likely require a significant look-back period and cause an already onerous process to become more challenging.

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[108] *Id.* at 108-46.
[109] *Id.*
[110] Telephone interview with CMS (Jan. 22, 2009).
[111] Meyer & Spires, *supra* note 45.

E. When to Report

Claims information must be reported after the RRE assumes ongoing responsibility for medicals or after a TPOC settlement has been reached, or a judgment, award or any other payment has occurred.[112] Claim Input files must be submitted to COBC on a quarterly basis during an RRE's assigned 7-day file submission time frame.[113] There is a grace period when the settlement, judgment, award or other payment is made within 45 days prior to the start of the seven-day file submission time frame.[114]

Quarterly Claim Input File Submission Timeframes[115]

Dates	1st Month	2nd Month	3rd Month
01 - 07	Group 1	Group 5	Group 9
08 - 14	Group 2	Group 6	Group 10
15 - 21	Group 3	Group 7	Group 11
22 - 28	Group 4	Group 8	Group 12

V. PENALTIES

Section 111 contains provisions which provide for serious consequences upon the failure of an RRE to comply with its terms.[116] The statute states, "[a]n 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. . . ."[117] At the present time it appears as though insurers will be strictly liable under this section for failure to comply with the reporting requirements.

In addition, CMS is entitled to recover penalties based on any other available remedy. For example, RREs may be required to reimburse

[112] Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 34.

[113] *Id.* at 33. (RREs receive their Claim Input File submission timeframe with the profile report sent after the COBC has processed their registration and account setup.).

[114] Press Release, MARSH & Am. Soc. For Healthcare Risk Mgmt., *supra* note 100.

[115] Ctrs. for Medicare & Medicaid Servs., *supra* note 4, at 33.

[116] 42 U.S.C. § 1395y(b)(8)(E)(2008).

[117] *Id.*

Medicare for any conditional payments made. Section 1395y(b)(2)(B)(iii), states, in pertinent part, when Medicare makes a conditional payment for medical services received as a result of an injury caused by another party, the government has a right of recovery for the conditional payment amount against any entity responsible for making the primary payment.[118] A conditional payment is: "A Medicare benefit payment made for any item or service to which the exclusion for third-party payers applies, [which] is conditioned on reimbursement to the appropriate Medicare Trust Fund when notice or other information is received regarding a beneficiary's entitlement to payment under a primary plan."[119]

In a recent decision, *United States v. Harris*, the United States District Court for the Northern District of West Virginia was asked to examine the ability of CMS to recover monies owed by a beneficiary from such beneficiary's attorney.[120] The court noted that to recover payment, "the government may 'bring an action against any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service . . . under a primary plan.'"[121] Primary plan is defined as a group health plan or large group health plan and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a

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[118] 42 U.S.C. § 1395y(b)(2)(B)(iii). "In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan." *Id.*; *see also* Cox v. Shalala, 112 F.3d 151, 154 (4th Cir. 1997) ("When such a conditional payment is made for medical care, the government has a direct right of recovery for the entire amount conditionally paid from any entity responsible for making primary payment.").

[119] 70C AM. JUR. 2D *Social Sec. & Medicare* § 2473 (2009).

[120] U.S. v. Harris, No. 5:08CV102, 2009 WL 891931, at *1 (N.D. W. Va. March 26, 2009) (holding that Plaintiff's attorney became liable to Medicare immediately when he made payment to his client, a Medicare beneficiary. Mr. Harris' client in a personal injury case had received Medicare benefits in the amount of $22,549.67. Mr. Harris settled the personal injury action for $25,000. He then distributed the settlement proceeds without reimbursing Medicare for its conditional payments. Medicare reduced its claim to $10,253.59, taking into account Mr. Harris' attorney's fees, costs, and the amount of the settlement. Having already disbursed the settlement funds, Mr. Harris ignored Medicare's rights. Thereafter, Medicare pursued Mr. Harris in court to recover its conditional payment).

[121] *Id.* at *3 (quoting 42 U.S.C. § 1395y(b)(2)(B)(iii)).

self-insured plan) or no fault insurance.[122] The government may also "recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity."[123] Such an entity is defined as "a beneficiary provider, supplier, physician, attorney, State agency, or private insurer that has received a primary payment."[124] Under *Harris*, an attorney may be held liable for monies due to CMS if her beneficiary client fails to make such payment. However, it appears as though this situation has rarely arisen. A Freedom of Information Act (hereinafter "FOIA") request submitted to CMS revealed on three instances in which "CMS or its agents took action to recover conditional payments under the [MSP] Program."[125]

Under 42 U.S.C. § 1395y, liability for conditional payments made by Medicare can be further extended to the RRE. There are a variety of methods by which an RRE may protect itself from lawsuits to recover conditional payments. First, an RRE may make a payment directly to Medicare for the conditional payments which have been made and then make any remaining payment to the claimant. Second, the RRE may name Medicare as an additional payee as a material term to the settlement agreement. Alternatively, the RRE may establish a policy of refusing liability payments to claimants who fail to provide the required information.

The case of *Breitkopf v. Krieger*[126] illustrates how these methods may be used in practice. In *Breitkopf*, the parties entered into a settlement agreement under which they agreed Medicare's rights had to be protected.[127] However, a dispute between the parties arose as to whether Medicare or CMS could appear as a payee on the settlement draft.[128] The claimant demanded a portion of settlement immediately, however, the insurer did not want to disburse the settlement proceeds for fear of the possibility that Medicare would pursue a claim against it if conditional payments were not repaid within 60 days.[129] The judge ordered half the money be paid to the claimant and the other half be placed in an escrow

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[122] 42 U.S.C. § 1395y(b)(2)(A).

[123] *Id.*

[124] 42 C.F.R. § 411.24(g)(2006).

[125] Hart v. U.S. Dept. of Health & Human Servs., 676 F. Supp. 2d 846, 852 (D. Ariz. 2009).

[126] No. 09-1890 (E.D. Pa. Nov. 2, 2009).

[127] *Id.*

[128] *Id.*

[129] *Id.*

account to be distributed to Medicare upon determination of the amount of conditional payments that had been made.[130]

Under an agreement where Medicare is listed as an additional payee to the settlement agreement, the plaintiff's or claimant's attorney or the claimant would be required to obtain CMS' endorsement on the check before distributing or depositing the funds. This would provide CMS with the opportunity to recoup any monies owed to it for conditional payments made. Defense counsel and insurance companies should ensure that the naming of Medicare as an additional payee is a material term to the settlement agreement and that the claimant and/or plaintiff is aware of this term. In the recent decision in *Tomlinson v. Landers*,[131] an insurer issued a settlement draft which included CMS as a payee after learning the Plaintiff was a Medicare beneficiary. The court rejected a Defendant's Motion to Enforce a Settlement on the ground that there was no "meeting of the minds" because the parties' settlement agreement did not include naming CMS as a payee.[132] Under *Tomlinson*, it is essential that insurers and their attorneys include such a term in the settlement agreement.

A. CONSTITUTIONAL ISSUES

A significant Eighth Amendment constitutional issue is raised by the imposition of heavy fines on RREs for non-compliance, particularly in situations where the RRE is unable to obtain the required information from claimants. The Eighth Amendment provides: "Excessive bail shall not be required, *nor excessive fines imposed*, nor cruel and unusual punishments inflicted."[133] The Excessive Fines Clause "limits the government's power to extract payments, whether in cash or in kind 'as punishment for some offense.'"[134] "The touchstone of the constitutional inquiry under the Excessive Fines Clause is the principle of proportionality: The amount of the forfeiture must bear some relationship to the gravity of the offense that it is designed to punish."[135] In *Bajakian* the Court held a punitive forfeiture is violative of the Excessive Fines Clause if the forfeiture is "grossly

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[130] *Id.*

[131] No. 3:07-cv-1180-J-TEM, 2009 WL 1117399 (M.D. Fla. Apr. 24, 2009).

[132] *Id*. at *3-5.

[133] U.S. CONST. amend. VIII (emphasis added).

[134] Austin v. United States, 509 U.S. 602, 610 (1993).

[135] United States v. Bajakian, 524 U.S. 321, 334 (1998) (Forfeiture of $357,144 in case, based on "solely a reporting offense" when defendant failed to declare that he was transporting more than $10,000 in currency out of the country, held constitutionally impermissible).

disproportional to the gravity of the defendant's offense."[136] Imposing a fine of $1,000 per day is arguably disproportional to the offense when imposed on an insured or self-insured that is unable to obtain necessary information from the claimant. Here again, shifting the burden of the penalties to the beneficiary would alleviate an issue created by the Section 111 reporting requirements.

B. PROCESS FOR AVOIDING PENALTIES IMPOSED BY CMS

RREs must take care to develop intensive methods for providing claimants with any necessary forms and documenting all communications with the claimant. For example, the RRE should deliver any required forms to the claimant via certified mail; this method will allow the RRE to develop a record of communications with the claimant. If a response is not received on the initial attempt, the RRE should again attempt to deliver the form via the same method and should document each attempt to deliver the form. Instituting these types of comprehensive practices may allow the RRE to bring possible challenges to any fines imposed upon it in relation to those non-cooperative claimants.

C. SITUATIONS WHERE PENALTIES SHOULD BE IMPOSED ON CLAIMANT

As discussed above, there are likely to be situations where a claimant refuses to provide accurate and complete information relating to Medicare beneficiary status, including their HICN and SSN, to an RRE. An RRE should not be held responsible for its non-compliance with the Section 111 reporting requirements where the RRE has made multiple attempts, in good faith, to retrieve the necessary information from the claimant and can show the claimant is acting to hinder recovery of such information and to prevent a determination of the claimant's Medicare beneficiary status. The burden of proof should be placed on the RRE to establish its good faith attempts to collect the necessary information and that the claimant has hindered that collection.

Where a RRE is able meet its burden it should be excused from monetary liability as to that particular claimant. However, Medicare should not be prevented from collecting monetary fines in this circumstance; instead, the penalties which are to be imposed on the RRE should be shifted to the claimant and/or their representative for their interference with

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[136] *Id.*

Medicare's ability to recoup any conditional payments, to ensure its position as secondary payer for future payments and/or to achieve the overall goal of protecting Medicare's future financial interests. Unlike the safe-harbor provisions which have been advocated by some industry professionals, which merely relieve all parties of liability, shifting the burden of financial penalties to the party responsible for non-compliance will serve the overarching goal of the Section 111 reporting requirements. Furthermore, shifting the burden to the claimant may provide an incentive for future claimants to comply with information requests sent by RREs. Therefore, shifting the financial burden will not only protect RREs from unreasonable penalties, but will result in a more effective process for CMS, RREs and claimants.

VI. HELPFUL SOLUTIONS

A. ERRORS & OMISSIONS INSURANCE POLICIES

The insurance industry has begun to offer new products in response to the reporting requirements. For example, American Empire Surplus Lines Insurance Company (hereinafter "American Empire"), a member of the Great American Insurance Group, has launched an errors and omissions (hereinafter "E&O") liability insurance product specifically designed for Medicare statutory compliance.[137] E&O insurance is "an agreement to indemnify for loss sustained because of a mistake or oversight by the insured."[138] Essentially, E&O coverage provides protection "in the event that an error or omission . . . has caused financial loss . . . ."[139] In regards to American Empire's new E&O product, Bob Nelson, American Empire's President and Chief Operating Officer stated:

> Our new policy, which provides E&O coverage for Medicare Statutory Compliance, is designed to help all entities who choose to self-insure their workers' compensation or third party liability exposures. The new Extension Act legislation has wide-ranging consequences

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[137] Press Release, Am. Empire Surplus Lines Ins., Am. Empire Surplus Lines Ins. Co. Launches E&O Liab. Ins. For Medicare Statutory Compl. (Nov. 9, 2009).

[138] BLACK'S LAW DICTIONARY (8th ed. 2004).

[139] Glenda Wertz, *The Ins and Outs of Errors and Omissions Insurance*, INS. J., July 19, 2004 *available at* http://www.insurancejournal.com/magazines/west/2004/07/19/features/44745.htm.

> to these employers, who may soon be confronted with demands from Medicare for reimbursement for claims they thought were settled.[140]

The use of an errors and omissions policy will be particularly useful for self-insureds, particularly those that are small companies, where their new Section 111 reporting requirements will seem particularly onerous. An errors and omissions policy like the one discussed above will reduce the risk associated with self-insureds by ensuring coverage where any compliance mistakes are made by the self-insured which would otherwise result in the imposition of heavy fines.

RREs should take into consideration numerous factors in determining whether or not to purchase an E&O policy to protect against non-compliance with the reporting requirements. For instance, in the event an RRE uses an agent as discussed above, it is important to discern whether the E&O policy will cover mistakes made by the agent. Further, as with any type of insurance, RREs must consider what this type of E&O policy will cost.

B. MEDICARE SET ASIDE ARRANGEMENTS

The central goal behind the new reporting requirements enacted through MMSEA is to provide Medicare with additional tools by which to seek reimbursements for Medicare claims. Completing CMS-approved set-aside arrangements, commonly referred to as MSAs, will effectively serve this purpose. A Medicare set-aside is "an allocation for future payments under an insurance claims settlement designated exclusively to pay for medical services that would be covered by Medicare if the injury/illness is not covered by a private insurance program."[141] Medicare set-asides are currently required only in workers' compensation settlements.[142] The widespread use of Medicare set-asides in other settlement agreements will ensure that Medicare's interests are being reasonably considered by the parties. The advantage of a Medicare set-aside arrangement is that when the set-aside amount has been completely exhausted, Medicare will become

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[140] Am. Empire Surplus Lines Ins., *supra* note 137.

[141] *A Closer Look: Medicare Set-Aside Arrangements Become an Issue for Risk Managers*, WORKPLACE STRATEGIES (MARSH, Global Offices) 2005, at 1.

[142] *See id.*

the primary payer and will be responsible for all future Medicare-covered expenses related to the injury.[143]

Under the current Medicare set-aside scheme for workers' compensation claims the following requirements must be met:

> (1) The claimant is currently a Medicare beneficiary and the total settlement amount is greater than $25,000; OR,
> (2) The claimant has a "reasonable expectation" of Medicare enrollment within thirty (30) months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $25,000.[144]

The amount of a set-aside arrangement varies on a case-by-case basis and should be approved by CMS. The approval process would allow CMS to evaluate the extent to which its interests are being considered and advise the parties as to what adjustments, if any, must be made in their computations. In computing the amount to be "set-aside" the parties should consider: "all future medical expenses (including prescription drugs), repayment of any Medicare conditional payments, previously settled portions of a workers' compensation claim, life expectancy, inflation, administrative fees, wages, and attorney fees."[145]

There are no current requirements that MSAs be used in the context of non-workers' compensation claims, including personal injury liability claims. However, using MSAs for these types of claims appears to be the most prudent way to protect Medicare's interests for future expenses

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[143] Berdy & Nichols, *supra* note 3, at 397.

[144] *Id.* at 396 (citing Ctrs. for Medicare & Medicaid Servs., Workers Compensation Medicare Set-aside Arrangement, *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp#TopOfPage); *see id.* (A claimant may have a "reasonable expectation" of Medicare enrollment when the individual (1) has applied for Social Security Disability Benefits; (2) has been denied Social Security Disability Benefits but anticipates appealing that decision; (3) is in the process of appealing and/or refiling for Social Security Disability Benefits; (4) is 62 and six months old; or, (5) has an End Stage Renal Disease condition but does not yet qualify for Medicare.).

[145] *Id.* Conditional payments are those payments made by Medicare to a provider for health care services. "Medicare can and will seek reimbursements from GHPs and non-GHPs for conditional payments made if it determines those payments were the responsible of a primary payer." *Id.* at 395.

and to protect RREs against future liability and fines. A system of MSA for personal injury liability claims could closely resemble the system currently in place for workers' compensation claims. If any scenario listed above exists, a set-aside arrangement would be an appropriate option.[146]

VII. CONCLUSION

In an attempt to "protect its future financial interests," Medicare has imposed stringent new reporting requirements on liability (including self-insurance), no-fault and workers' compensation insurers. These new reporting requirements present a variety of obstacles which make strict compliance difficult for these entities. Lack of strict compliance can lead to the imposition of stiff monetary penalties on these entities, as well as liability for any other remedies available to CMS. The simplest way to avoid liability is for the RRE to retain reporting duties within itself, not to outsource that responsibility to agents. That is because RREs may not transfer its duty to report, that is, it will always be liable for errors and non-compliance, regardless if it actively participates in the actual reporting process.

Affected entities need to take care to ensure they determine the proper RRE for reporting purposes and that the RRE makes any and all attempts to ensure compliance. Ensuring compliance with the reporting requirements will be particularly difficult because the RRE must rely heavily on the trustworthiness and cooperation of the claimant who for all intents and purposes has little incentive to honor any information requests from the RRE. For this reason, the burden of penalties should be shifted from the RRE who attempts in good faith to the uncooperative claimant who through his or her actions is essentially interfering with Medicare's right to protect their interests.

As CMS works through the implementation of the mandatory reporting requirements, more "alerts" and information are sure to come. Until then, the hurdles and obstacles faced by RREs and their attorneys will remain great. And until then, entities involved in the liability (including self-insurance), no-fault, and workers' compensation insurance industry must be sure to determine their status as an RRE and comply with the current reporting requirements.

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[146] *Id.* at 401.