Get Ready for MIR

(No More Avoiding Medicare)

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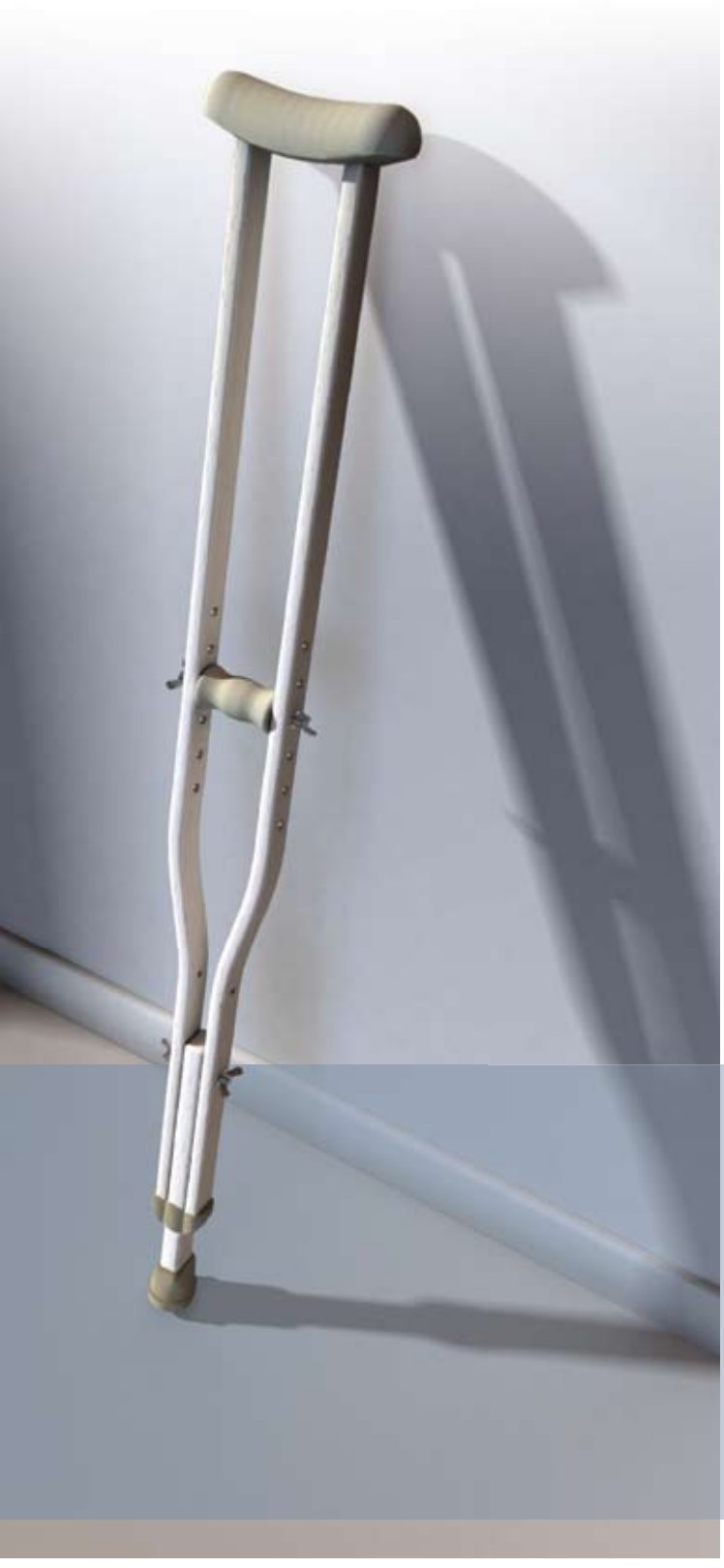

Say "MIR" and most people think of the Russian space station. Now MIR refers to a new federal law that is causing headaches for parties to personal injury claims.

Mandatory Insurer Reporting refers to the requirements of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) signed into law in late 2007.[1] The intent of MIR is to save billions of dollars in government payments for health care. The new source of those payments? The government health-care beneficiaries themselves, along with insurers and self-insureds.

Consider an injured claimant who settles her claim (including compensation to pay future medical expenses) with a self-insured respondent or an insurer. Instead of setting part of the settlement aside to pay for ongoing medical expenses related to the injury, the claimant may have those medical expenses charged to Medicare, Medicaid, or SCHIP if she qualifies for one of those programs.

In some personal injury claims, the responsible party—employer, tortfeasor, or insurer—is obligated to pay the injured party's related medical expenses for life (think workers' compensation and no fault, in particular). If the claim is settled, many of those future medical expenses that would have been paid by the responsible party but for the settlement might end up being paid by one of the government medical plans. Settled claims can mean big savings on future medical expenses for insurers and self-insureds and correspondingly big outlays for government-run health plans. While the Medicaid and SCHIP programs have their own requirements for reporting situations in which a plan beneficiary may be entitled to have medical expenses paid or reimbursed by a third party, the new reporting requirements contained in MMSEA apply only to personal injury claims of those eligible for Medicare, so the rest of this article will apply only to the Medicare program.

Fast Facts:

- Some parties to personal injury settlements of Medicare beneficiaries have neglected the duty to report the claims to Medicare and to protect Medicare's interests in the settlements.
- Congress created new requirements for reporting injury claims of Medicare beneficiaries and has demonstrated that it will not tolerate failure to report: a civil fine of $1,000 per claim for every day reporting is delayed.
- Medicare is entitled to reimbursement of its payments for treatment of claim-related injuries.

Enforcing Medicare Secondary Payer

Over 20 years ago, Congress recognized the need to protect government health-care programs from beneficiaries, insurers, and self-insureds who wanted to replace their wallets with Uncle Sam's. The Medicare Secondary Payer (MSP) statute essentially provides that Medicare need not pay medical expenses of beneficiaries whose expenses are payable by a group health, workers' compensation, liability, or no-fault insurance policy or self-insurance plan.[2]

To taxpayers funding Medicare, the MSP law sounds great. Make the parties liable for the injury—not Joe Public—cover the medical expenses of injured parties. But, for the Centers of Medicare and Medicare Services (CMS), the government agency responsible both for paying many government health-care benefits and enforcing the MSP law, proving which of its beneficiaries are entitled to have payments made by insurers or self-insurers has not been easy.

Sometimes the parties involved in the settlement of a personal injury case of a Medicare beneficiary ignore the legal obligation to report to CMS the fact that the Medicare-beneficiary claimant has filed a claim for medical expenses that may in fact have been paid at least in part or may in the future be paid at least in part by Medicare. Those same parties may fail in the obligation to reimburse Medicare for the payments it made for treatment of the injury on which the claim was based.

MIR will help fix that problem. Beginning January 1, 2010, workers' compensation, liability, no-fault insurers, and self-insurers will be required to provide information to CMS on each claim of a Medicare beneficiary. And what is one of the triggers prompting reporting? Payment of a settlement, award, or judgment.

With the reporting MIR requires, it will be simple for CMS to figure out which beneficiaries settled personal injury cases and which of those beneficiaries failed to reimburse conditional Medicare payments or otherwise protect Medicare's interests under the terms of the settlement.

Congress sent a strong signal to those involved in the handling of personal injury claims by providing a healthy financial penalty for MIR noncompliance: $1,000 per claim for every day's delay in reporting applicable claims to CMS. Ouch. Federal law already provides that Medicare can seek recovery of twice the amount of its conditional payments plus interest from any person who received a payment (including a settlement payment) from the insurer or self-insured responsible, including the beneficiary and the beneficiary's attorney.[3]

Liability: Not an Issue

In every claim, a critical issue is liability. Sure, the injured party claims the respondent is liable for the injury and obligated to pay for medical expenses related to the injury. But, before talk of paying money gets underway, it must first be established that the facts and law support the assertion that *this* respondent really is obligated to *this* claimant for *this* injury.

> Since workers' compensation and no-fault files can require payments for the claimant's lifetime, many "old dog" files will need review and updating. And there will certainly be fear of awakening sleeping dogs.

Until recently, some claims professionals took the position that they did not need to protect Medicare's interests in claims in which liability was never established either by the facts or the law. There have always been claims in which liability was denied and a nuisance settlement reached to get the file closed. No need to worry about CMS in those cases, right?

Wrong! The MSP statute was amended a few years ago to add language making it clear that the parties to personal injury claims must protect Medicare's interests if a payment is made to the claimant—even when liability is either denied or never established.[4] Even a nuisance settlement in which the claimant admits a lack of liability will establish the respondent as primary to the government health-care plan.

No Expansion of Set-Asides

With the MSP law, the parties to personal injury claims became obligated to protect the interests of Medicare when settling their claims. In the past, "protecting the interests of Medicare" was thought of as simply reimbursing Medicare for any past payments related to the injury.

One question has arisen in response to MIR: can we expect to have to start worrying about "Medicare set-asides" in claims other than workers' compensation? Expanding Medicare set-asides into insurance coverage lines other than workers' compensation has been anticipated for some time. And some claims professionals are already requiring language in settlement documents (especially

in bigger cases), evidencing the steps that were taken to protect Medicare's interests. Medicare set-asides to cover future medical expenses have begun showing up in some liability and no-fault case settlements even though not specifically required by CMS. But such set-asides are not required by CMS, and nothing in the MIR statute or the administrative rules being developed under MIR portends the creation of set-asides in non-workers' compensation cases.

Impact on Claims Handling and Litigation

Even though reporting under MIR won't begin officially until January 1, 2010, it is already creating changes in the way personal injury claims are being handled by attorneys, insurers, and claims administrators. CMS is requiring that insurers and self-insureds report a massive amount of data, much of which the reporting parties don't currently have. The reporting format CMS will require has more than 100 data elements, including information about the claimant, the insurer (or other respondent), the injury, the cause of the injury, what payments have been made to the claimant, and who is representing the claimant. Attorneys representing claimants may not be happy to discover that CMS wants the *attorney's* name, address, phone number, and tax identification number. Oh boy.

To make acceptable reports to CMS, respondents will have to gather a lot of information, revise their claims systems to capture the required data, and change the way information is gathered to make sure the required data is obtained. There will be changes in how discovery is conducted in personal injury cases and how settlements are negotiated. Undoubtedly some respondents will insist on changes in release language, possibly seeking indemnity from the claimant or the claimant's attorney relative to Medicare compliance issues. Cooperation in providing CMS-required information will be a condition of settlement.

One of the key missing pieces of information in many claim files is the claimant's Medicare eligibility status. Claim handlers will need to find out which of their claimants are Medicare beneficiaries. To help in that process, CMS is providing insurers and self-insurers with the ability to send a list every 30 days of claimant names, addresses, birth dates, and Social Security numbers to CMS to ask if any of those claimants are on Medicare. CMS will respond with a simple "yes" or "no" for each claimant. But that query function assumes that the claimant's Social Security number is known to the insurer or self-insurer, which is often not the case. Clearly, demands for Social Security numbers are going to be an increasing part of claim investigation, formal discovery, and settlement negotiation.

Other Reporting Trigger: ORM

MIR requires reporting not only of personal injury claims of Medicare beneficiaries resolved by payment of a settlement, award, or judgment, but also of personal injury claims in which the insurer or self-insured has accepted "ongoing responsibility for medical" (ORM) payments. This will apply essentially in workers' compensation and no-fault claims—those cases in which payment for medical care over a period of time is required. Even if the insurer or self-insured has made no payment of any kind, that claim must be reported under MIR if responsibility has been accepted for payment of current or future medical expenses in a case involving a Medicare beneficiary.

Determining which cases involve both responsibility for ongoing medical payments and a claimant who is on Medicare presents another big headache for claims administrators. Since workers' compensation and no-fault files can require payments for the claimant's lifetime, many "old dog" files will need review and updating. And there will certainly be fear of awakening sleeping dogs. It will come as no surprise to find inactive ORM files in which an insurer or self-insured has an obligation to pay for medical treatment that Medicare has in fact been paying, maybe for many years. Some big Medicare reimbursement claims may be in the offing.

Growing Interest

Currently, much of the interest in and activity involving MIR has been on the part of workers' compensation, no-fault and liability insurers, self-insureds, and claims administrators. They are scrambling to be ready to begin reporting claims to CMS. Even before that reporting begins, the activity required in gathering new and more information on pending personal injury claims and contacting claimants, claimants' attorneys, insureds, and policy holders to get that information is beginning to stir up a hornet's nest. And once reporting begins, there is certain to be much more interest in this topic as CMS begins to demand reimbursement of past Medicare payments from claimants, claimants' attorneys, insurers, and self-insureds. ■

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FOOTNOTES

1. PL 110-173, 121 Stat 2492.
2. 42 USC 1395y(b).
3. 42 CFR 411.24.
4. 42 USC 1395y(b)(2)(B)(ii).