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Emerging Strategies for Risk



HOUSE SPEAKER Nancy Pelosi, Democrat from California, center, speaks at a press conference on Capitol Hill in Washington, last October after the House failed to override President Bush's veto of the spending increase for the State Children's Health Insurance Program (SCHIP). From left are: House Majority Leader Steny Hoyer, D-Md.; Rep. Charles Rangel, D-N.Y.; Pelosi; Rep. John Dingell, D-Mich.; Rep. John Larson, D-Conn.; and Rep. Xavier Becerra, D-Calif.

● HEALTH CARE

SCHIP: “Live” Ordinance Or Dud?

What does the SCHIP Extension Act claim reporting requirements have to do with the Medicare Secondary Payer Law? Directly, nothing—indirectly, everything. **BY JOHN V. D'ALUSIO**

Introduced in 1981 as part of the Omnibus Budget Reconciliation Act (OBRA), the Medicare Secondary

Payer (MSP) law was intended to preclude Medicare from making payments for conditions that were

the responsibility of a primary payer—workers' compensation, liability and no-fault insurance.

The law sat quietly on the books for 25 years until the Centers for Medicare and Medicaid (CMS) formally announced its intention to enforce Medicare's right of protection on claim settlements. Initially heralded as Armageddon for the property-casualty claim industry, the industry awaited an apocalypse—one that failed to materialize.

Just as complacency in the industry set in, the 2007 Medicare, Medicaid and SCHIP Extension Act was passed—once again the horizon darkened ominously. It remains to be seen if this new precept will be deliverance or another mirage.

The MSP law as included in the 1981 OBRA dictates that Medicare must be protected as a secondary payer when a primary payer exists. This protection applies if the injured party is Medicare entitled, or has potential Medicare entitlement within 30 months of the date of settlement.

Additionally, Medicare is due protection in two directions. First, they are due protection for past “conditional payments” for which Medicare has a statutory right of recovery. Second, Medicare is afforded future protection from any future payments post settlement—a requirement which drove the creation of Medicare Set-Aside allocations (MSAs) as a vehicle for the safekeeping of the funds with which to protect Medicare on each applicable claim.

With no blanket enforcement by CMS, the law and later edicts requiring compliance fell flat. Despite the fact that the technology and tracking mechanisms are in place to accurately match Medicare recipients who also have property and casualty claims, continued widespread enforcement is still not in effect.

The lack of CMS resources and the CMS presettlement MSA approval requirements are the primary contributing

factors which have weakened enforcement. In the latter situation, CMS enforcement was aimed at the workers' comp claims arena. The seven memoranda distributed by CMS between July 2001 and July 2006, establish CMS submission policies and procedures for MSAs on workers' comp claims. Similar MSA presettlement CMS written approval policies do not currently exist for liability and no-fault cases.

Adherence to the MSP to date has largely been voluntary on the part of claims handlers—especially on nonworkers' comp claims where CMS has yet to issue presettlement MSA approval procedures. So what has changed?

On Dec. 29th, 2007, the Medicare, Medicaid and State Children Health Insurance Program (SCHIP) Extension Act was signed into law. Section 111 of this law is directly relevant to the Medicare Secondary Payer Law, though from a tangential standpoint.

The SCHIP Extension Act requires workers' comp, liability, and no-fault claim handlers to report all cases to the Secretary of Health and Human Services (HHS) when the injured claimant is Medicare entitled. The Act reinforces Medicare's status as a secondary payer, intending to help secure the agency's long term financial viability and clearly defines the three lines of coverage—workers' comp, liability and no-fault—as primary payers through the reporting requirement and thereby eliminating any ambiguities on the responsibility and

subjectivity of all three lines to the legislative requirements for primary payers.

The penalty under the law for not reporting these claims is staggering—\$1,000 per day, per file for as long as the claim is not reported. Therefore, each nonreported case has a potential fine of \$365,000 annually. The collected fines will be deposited into the Medicare Trust Fund. The power to fine commences on July 1, 2009.

So what does the SCHIP Extension Act claim reporting requirements have to do with the Medicare Secondary Payer Law? Directly, nothing—indirectly, everything.

THE REPORTING REQUIREMENTS

The reporting to HHS (or the designee) must be electronic in nature. No paper reporting will be accepted. Electronic reporting will be in an ISO reporting format. HHS will accept three forms of electronic reporting; direct, third party, and web-based.

Reporting is required at time of claim payment to a Medicare entitled or, in a workers' comp case, when compensability is determined.

The reporting data elements will include: claimant name, address, social security number, gender, date of birth, D/A, claim number, policy number, body parts impacted by the injury, description of injury, and date of resolution and amount paid.

The frequency of reports is to be monthly. The SCHIP Extension Act does not have a direct impact on the Medicare Secondary Payer Law of 1981. The SCHIP Act imposes new claim reporting requirements on claims handlers, which are in addition to the necessity of protecting Medicare as a secondary payer under the MSP.

In essence, the SCHIP Act will require claims handlers to provide HHS with a list of all cases in workers' comp, liability and no-fault where the injured party is Medicare

Summary

- The SCHIP Extension Act requires workers' compensation, liability, and no-fault claim handlers to report all cases to the Secretary of Health and Human Services (HHS) when the injured claimant is Medicare entitled.
- Fines, which begin next July, are as high as \$1,000 a day.
- Medicare will now be privy to the SCHIP reports illustrating each reporting entities' workers' comp, liability and no-fault claims where the injured party is Medicare entitled.

entitled. There is a “Sharing of Information” clause in the SCHIP Extension Act. Since CMS is part of HHS, it is understood that HHS will share the reports with CMS, the entity responsible for the enforcement of the MSP.

CMS will receive a report outlining every case where Medicare should be protected under Title 42 as a secondary payer if the claim is settled and the resolution involves irrevocable closure of future medical benefits.

In early August, CMS issued its MSA submission requirements for workers’ comp and nonworkers’ comp claims. In the past, this had resulted in random and variable compliance with the MSP on liability cases. However, now the claims handlers will be forced to submit a “target rich environment” listing to HHS that includes liability and no-fault claims, as well as workers’ comp cases.

In order to drive further MSP compliance, CMS will now possess a list of claims from which they can select cases to audit. The next logical question is “Will they do this?”

It is no secret that CMS is not rich in federal funding. However, in the past when internal CMS funding issues came to the forefront on MSP enforcement, CMS responded by hiring subcontractors to assist their MSP enforcement efforts—Life Care Management Partners as the WC Review Committee and Chickasaw Nation Industries as the Coordination of Benefits (COB) subcontractor.

Purportedly, \$35 million is being earmarked by Medicare to promote enforcement of the SCHIP reporting requirements. This enforcement is expected to result in fines that will pay back the investment by a multiple of 30. Obviously, this type of compliance monitoring will also have an impact on MSP legal obligations. The Congressional intent with both the MSP and

UNLIKE THE PRESENT SPORADIC EFFORTS TO IDENTIFY CLAIMS WHERE MEDICARE SHOULD BE PROTECTED AS A SECONDARY PAYER, UNDER THE SCHIP ACT THERE WILL NOW BE A LIST—PROVIDED BY THE REPORTING ENTITIES—WHERE MEDICARE’S INTERESTS SHOULD BE TAKEN INTO CONSIDERATION.

SCHIP Act is to help preserve the fiduciary health of the Medicare federal entitlement program by only extending benefits for treatment where a primary payer does not exist.

Unlike the present sporadic efforts to identify claims where Medicare should be protected as a secondary payer, under the SCHIP Act there will now be a list—provided by the reporting entities—where Medicare’s interests should be taken into consideration. This new measure will morph the enforcement of the MSP from a haphazard effort largely focused on workers’ comp claims to a focused effort driven by the list of files reported to HHS. The fines are so punitive, that non-reporting is not an option. Compliance with SCHIP reporting requirements is a foregone conclusion, given the fining exposure. So where does this leave the issue of adherence to the MSP?

There are no fines of the nature of the SCHIP Act in the MSP. Medicare may seek double damages on recovery of conditional payments, but that is only assessed if Medicare is forced to file a legal action to perfect recovery. Medicare may suspend the claimant from future Medicare benefits relative to Medicare covered treatment for the condition related to the injury if their interests are not protected, and take credit to abide on the entire amount of settlement before beginning Medicare payments again.

However, that does not constitute a fine of the primary payer—though it may lead to

a “bad faith” extra-contractual action on the part of the claimant. Medicare may also file a separate action to enforce their rights under the MSP against any responsible party, but in this remedy there are no civil money penalties along the lines of the SCHIP Act.

The fact of the matter is that Medicare will now be privy to the SCHIP reports illustrating each reporting entities’ workers’ comp, liability and no-fault claims where the injured party is Medicare entitled. If these workers’ comp and liability claims are resolved by settlement—no-fault claims are not settled, they are paid until policy limits are exhausted or the injured person’s medical condition improves—and Medicare’s interest is not taken into consideration, it will be rather easy for CMS to discover this situation. CMS can audit a few cases from the list and if a trend of non-compliance is evident a more comprehensive review may be initiated. This will open the SCHIP Act reporting entity to further exposure on the MSP.

The SCHIP Act reporting requirements should have a direct impact on additional enforcement of the MSP by CMS. To ignore this developing situation is to court difficulties where no defense will suffice—as there is no defense for not obeying the law.

JOHN V. D’ALUSIO is vice president training and industry education, PMSI MSA Services. He can be reached at riskletters@lrp.com.



msa

*Formerly Health Advocates Inc.
and HAI West*

www.pmsionline.com ■ 888.MSA.PMSI