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President Obama Signs Medicare Secondary Payer Reform Legislation into Law

On Thursday, January 10, 2013, the President signed into law H.R. 1845, the "Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012". In addition to establishing a demonstration project to evaluate the benefits of allowing Medicare Part B coverage for in-home intravenous treatments for patients with primary immune deficiency disease, the Act also includes amendments to rules under which Medicare is a secondary payer to specified third party payers. These Medicare Secondary Payer provisions go into effect at varying times, ranging from six months from enactment of the act to January 1, 2014, and provide statutory guidance for situations when Medicare is a secondary payer for the plaintiff in a liability lawsuit.

Section 201 – Determination of Reimbursement Amount Through CMS Website

Section 201 of the Act provides for an alternative procedure for determination of the final conditional reimbursement amount through the use of the CMS website. This procedure is an option in addition to the procedure presently provided for by CMS and its contractors. Under this section, the claimant or the applicable plan may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify CMS that a payment is reasonably expected and the expected date of the payment. CMS then has 65 days to produce a demand letter, but it may extend that timeline a further 30 days. After this time period has lapsed, the parties can retrieve the demand information from the CMS website and rely on it so long as the settlement occurs within 120 days of notice and 3 days from the last download of the demand information from the website. If the parties take this route, the demand made by CMS is final and not subject to appeal.

In the event that the individual or authorized representative believes there is a discrepancy with the statement of reimbursement amount. After the individual or authorized representative provides documentation explaining the discrepancy and a proposal to resolve it, CMS has 11 business days after receipt of the documentation to determine whether there is a reasonable basis to include or remove claims on the statement of reimbursement. If CMS does not make any determination within the 11 days, then the proposal to resolve the discrepancy is accepted.

Section 201 also grants a right of appeal to insurance carriers and other primary payers, to be further fleshed out by regulations promulgated by CMS.

Section 202 – Establishing a Threshold

Section 202 of the Act is effective on January 1, 2014, applies to liability claims other than ingestion, implantation, and exposure cases, and it establishes an annual threshold under which there is no obligation to repay Medicare under 42 U.S.C. § 1395y(b)(2)(B)(ii) or to report under 42 U.S.C. § 1395y(b)(8). The annual threshold amount is to be published by CMS no later than November 15 of the previous year (the

first such amount to be published by November 15, 2013, for calendar year 2014), and is to be set at an amount where the estimated average amount to be credited to the Medicare trust funds of collections of conditional payments arising from liability insurance shall equal the estimated cost of collection incurred by the government for conditional payments arising from liability insurance.

Section 203 – Relaxing the civil penalty for non-compliance with reporting requirements, by making it discretionary

Section 203 of the Act amends the civil penalty amount for non-compliance with the Medicare Insurance Reporting law from a mandatory $1,000 for each day of non-compliance of each claimant to a discretionary "**up to"** $1,000 for each day of non-compliance of each claimant. This amendment thus adds discretion to the civil penalty provision. Section 203 also requires CMS to solicit proposals within 60 days of the enactment of the Act for regulations specifying practices for which the civil penalty will and will not be imposed, including specifically not imposing the penalty for good faith efforts to identify a Medicare beneficiary.

Section 204 – No longer requiring the use of Social Security or Health Identification Claim numbers to meet reporting requirements

Section 204, which is effective 18 months after the enactment of the Act, mandates that CMS is to modify the reporting requirements so that plans complying with the reporting requirements are no longer required to access or report to CMS beneficiary social security account numbers or health identification claim numbers. The Section allows for a process by which CMS may postpone the effective date by up to a year if the original effective date threatens patient privacy or the integrity of the secondary payer program.

Section 205 – Statute of limitations for certain claims brought to enforce reimbursement claims and penalties

Section 205 establishes a statute of limitations, effective six months after enactment of the Act, which limits actions brought by the U.S. pursuant to 42 U.S.C. § 1395y(b)(2)(B)(iii) to enforce reimbursement claims and penalties for any workers' compensation, liability, or no fault claim to three years from the Mandatory Insurance Report of a settlement, judgment, award, or other payment. In order for this statute of limitations to be triggered, the claim must have been electronically reported under 42 U.S.C. § 1395y(b)(8).

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