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MMSEA Reporting Requirements Raise Privacy Concerns

On January 1, 2011, rules go into effect that require reporting to the Centers for Medicare and Medicaid (CMS) settlement amounts paid to current or future Medicare beneficiaries. These reporting requirements are associated with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).[i] In striving to comply with these statutory requirements, defense counsel is often faced with balancing his or her obligation to CMS with plaintiff counsel's unwillingness to disclose personal plaintiff information necessary for proper reporting. Fortunately, courts across the country have started to weigh in on whether plaintiffs must disclose this personal information, providing defense counsel with authority on which to challenge plaintiff counsel's opposition to disclosure.

BACKGROUND

MMSEA is a 2007 amendment to the Medicare Secondary Payor (MSP) rule that has been in effect since 1980.[ii] To be sure, the Amendments do not create new reporting requirements, but rather provide a mechanism through which CMS is able to track amounts it is owed for items and services previously provided to beneficiaries.[iii]

Overall, the Amendments shift the regulatory burden from insured to insurer, requiring that an insurer, or Responsible Reporting Entities (RREs), report any payments on a claim in a typical liability settlement situation. The Amendments include, but are not limited to, requirements that a primary insurer 1) determine whether a Claimant qualifies for Medicare benefits now or in the future; and 2) notify CMS when the primary insurer resolves a claim with a current or future benefits recipient.[iv] According to CMS, the agency that administers Medicare and runs the reporting program, an injured individual who is not currently receiving benefits "should ... consider Medicare's interests when the injured individual has a 'reasonable expectation' of Medicare enrollment within 30 months of the settlement date, and the anticipated total settlement amount for the future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000."[v] Therefore, the primary insurer should contemplate protecting itself from not only a current but a future Medicare "super lien."

Settlements finalized on or after October 1, 2010 are subject to these reporting requirements. The Amendments do not specify a time frame in which Medicare must be notified of resolution of a claim, but reporting duties generally arise with payment of the claim. Section 111 categorizes settlements and judgments

as either a total payment obligation to claimant (TPOC) or as an ongoing responsibility for the claimant's medical expenses (ORMs). TPOCs are limited to the amount actually paid by the primary payer, while ORMs include the amount of future medical expenses assumed by the primary payer. The obligation to report TPOCs and ORMs arises at the time of the settlement or judgment; ORMs require additional reporting as additional payments are issued.[vi] RREs must report when they first assume ongoing responsibility for a claimant's medical expenses and again when their obligations to pay the claimant's medical expenses cease.[vii]

In order to avoid penalties, the insurer/RRE should notify CMS that payments could potentially be made as soon as negotiations with the potential beneficiary begin and/or before trial begins. While reporting requirements differ slightly for Group Health Plans and Non-Group Health Plans (i.e. Liability Insurers, Self-Insurers, No-Fault Insurance and Workers' Compensation), all RREs must include some form of claimant or beneficiary identifying information so CMS can correctly associate the claimant/beneficiary to the reported information.

PRIVACY CONCERNS

As RREs take steps to notify CMS of settlements, plaintiffs and their counsel have voiced objection to submitting social security numbers [SSNs] to CMS for payment processing. [viii] Plaintiffs are uncomfortable with providing this level of sensitive information, and are concerned that the defense will have access to and be able to use SSN info for purposes other than reporting.

Conversely, CMS needs this beneficiary-specific information in order to accurately coordinate payments, and has collected this type of information since the inception of the Medicare program. CMS has not stated whether a plaintiff who refuses to submit his/her SSN (or health insurance claim number or employer identification number) will be found to have not complied with the reporting requirements of Section111. However, CMS has stated that state restrictions on SSN use and collection "do not preempt the MSP statutory or regulatory provisions or the 'permitted use' provisions of the HIPAA [Health Insurance Portability Act] privacy rules . . . Such state laws are permissible, to the extent they augment but do not conflict with or constrain the requirements of federal laws or regulations." [ix]

CASE LAW

Courts have started to consider whether or not a settlement can be conditioned on a plaintiff's disclosure of SSN information. In *Seger, et. al. v. Tank Connection, LLC, et. al.,*[x] plaintiff was injured and sustained life threatening injuries while engaged in the galvanization of allegedly defective I-beams manufactured by defendants. Through the course of discovery, plaintiff was served with Interrogatories seeking information on plaintiff's Medicare and Social Security benefits, including his social security number; defendants sought this information in an attempt to comply with MMSEA reporting obligations. Plaintiff failed to provide this information and objected to these interrogatories.

Defendants argued that plaintiff's social security information was admissible and relevant to its defense pursuant to Fed.R.Civ.P. 26(b)(1): "without this information, [defendants] will have difficulty evaluating plaintiffs' claims as they do not have access to the amount Medicare has paid for [plaintiff's] care."[xi] By propounding these interrogatories, defendants were simply attempting to determine what amounts the insurers may later be required to reimburse to Medicare.

Plaintiffs and defendants agreed that Medicare information of a claimant or beneficiary need not be provided to CMS until "after the claim is resolved through a settlement, judgment, award or other payment."[xii] Defendants argued, though, that obtaining this information from plaintiff post-judgment may prove difficult as plaintiff would have no incentive to provide this information. Plaintiff, on the other hand, argued that defendants had ample evidence beyond a response to propounded interrogatories that would allow them to properly assess plaintiff's injuries and Medicare status.

In finding that plaintiff should respond to defendants' interrogatory and supply the requested information, the court noted that the Act merely enhanced already-existing reporting requirements. The court agreed that the Act does not required this information be submitted to CMS until after a final settlement

or judgment is issued, but also agreed that there is no harm to plaintiff in providing this information in advance of same. Unless plaintiff could prove that providing this information was unduly burdensome, which he was unable to do, the court found that defendant was otherwise entitled to this information. The court also pointed out that "the new reporting requirements affect all parties involved in a payment of a settlement, judgment or award,"[xiii] eliminating the idea that reporting is only a matter for one side or the other to address.

Relying on *Seger*, the court in *Hackley v. Garafano*[xiv] found that a defendant could permissibly condition disbursement of settlement funds on a plaintiff providing his or her social security number. Hackley, a minor, brought suit by and through his father for injuries allegedly sustained in an accident with defendant. Defendant's insurer, USAA, offered to settle the case, and plaintiffs accepted but refused to disclose their social security numbers to defendant's insurer; in turn, USAA refused to deliver settlement funds until provided with social security info from both plaintiffs. USAA stated to the court that, in seeking plaintiffs' social security information, it was simply attempting to comply with MMSEA reporting requirements; USAA indicated that plaintiffs' information would be protected by USAA's own internal privacy policy.[xv] Upon USAA's refusal to release settlement funds, plaintiffs filed for default judgment in the amount of the settlement, plus interest. The court was faced with two issues in ruling on plaintiffs' motion for default: whether an insurer may condition settlement on receipt of plaintiffs' social security numbers, and whether the terms of the settlement at issue were unambiguous so as to be enforceable through judgment.

Although recognizing that the decision of a federal magistrate is not binding on a Connecticut state court, the court found the reasoning in *Seger* persuasive, specifically noting that, " . . . the Nebraska court [in *Seger*] pointed out that among the purposes of the statute was avoiding having insurers 'at the mercy' of plaintiffs when the time comes to ascertain Medicare eligibility. Rather than having to rely on plaintiffs' representations, the statute expresses a preference for a standardized procedure based on social security numbers or Medicare Health Insurance Claim Numbers with which the insurer can make the determination electronically." [xvi]

The court used this logic to defeat plaintiffs' argument that settlement should not be contingent on plaintiffs' providing the minor plaintiff's or father's social security number – according to the *Hackley* court, plaintiff's minority did not absolve him from providing social security information; further, plaintiff's father, as plaintiff's representative and next of kin, was involved in payment of a settlement, and providing his social security number was not irrelevant to affecting settlement.[xvii] The court ultimately held that USAA could condition disbursement of settlement funds on plaintiffs' disclosure of their social security numbers.[xviii]

In its concluding statements, the *Hackley* court recognized that this was hardly the first or only settlement to be derailed due to unresolved Medicare lien questions; the court, however, admonished counsel to educate themselves on developing areas of the law affecting his or her area of practice: "Counsel would therefore be well advised to be aware of developments in this area of law and take them into account in fashioning unambiguous settlement agreements."[xix]

SUMMARY

As stated above, the Amendments require group health plans, liability insurers, no-fault insurers and workers' compensation insurers to report information to CMS about payments to Medicare beneficiaries. This information assists CMS in coordinating benefits paid to individuals for whom Medicare is the secondary payer, enabling CMS to stop making payments when another entity is required to pay, and to recover past payments another insurer should have primarily paid.

Defense counsel must first determine whether a plaintiff is, or could potentially become, a Medicare beneficiary, and can do so using a variety of tactics: serve Interrogatories that seek social security number(s) and Medicare information; look to hospital records and medical bills to learn the full extent of plaintiff's Medicare history; fully cooperate and engage in information sharing with plaintiff counsel from the beginning of a claim or lawsuit. In cases where

settlement is likely, defense counsel would be well advised to initiate discussions with plaintiff counsel regarding indemnity language that favors the RRE, and language that addresses responsibility for future Medicare set-asides at the outset of a case. No entity or party is immune from reporting responsibilities and, as set forth by the *Seger* and *Hackley* courts, all parties must cooperate to ensure obligations to CMS are met.

ENDNOTES

i "Overview," CMS Mandatory Insurer Reporting, Centers for Medicare & Medicaid Services, August 3, 2010, November 15, 2010, www.cms.gov/MandatoryInsRep/01_Overview.

ii 42 U.S.C. §1395y(b)(7)&(8).

iii "MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting, Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Version 3.1," Centers for Medicare & Medicaid Services, July 12, 2010, November 15, 2010, www.cms.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.

iv 42 U.S.C. §1395y(b)(7).

v See 42 C.F.R. §411.45(a)(2), .53(2); see also "Overview," CMS Mandatory Insurer Reporting, Centers for Medicare & Medicaid Services, *supra*.

vi "MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting, Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Version 3.1," page 18, *supra*.

vii "MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting, Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Version 3.1," page 10, *supra*.

viii Office of Financial Management/Financial Services Group, "Collection of Medicare Health Insurance Claim Numbers (HICNs), Social Security Numbers (SSNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers) – Alert," Centers for Medicare & Medicaid, April 6, 2010, October 26, 2010, www.cms.gov/MandatoryInsRep/Downloads/RevisedCollectionSSNEINs.pdf.

ix "Supporting Statement for the Medicare Secondary (MSP) Mandatory Insurer Reporting Requirements of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)," Centers for Medicare and Medicaid, August 28, 2008, October 26, 2010, www.cms.gov/mandatoryinsrep.

x *Seger, et. al. v. Tank Connection, LLC, et. al.*, Docket No. 8:08CV75 (D.Neb.2010).

xi *Id.* at 2.

xii *Id.* at 3.

xiii *Id.* at 5.

xiv *Hackley v. Garofano*, 2010 WL 3025597 (Conn.Super).

xv *Id.* at *2.

xvi *Id.* at *4.

xvii *Id.*

xviii In response to plaintiffs' assertion that the terms of settlement agreement were ambiguous, the court did not enforce the settlement agreement because there was no meeting of the minds – while the monetary terms were clear, USAA's requirement that plaintiffs' social security numbers be disclosed prior to payment of settlement funds was not a term agreed to by all parties.

xix *Id.* at *6.