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New Reporting Requirements May Impact The Settlement Of Employment-Related Claims

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Beginning on January 1, 2011, certain employers and insurers were required to report settlements, judgments or awards, where medical expenses are paid to a Medicare-eligible claimant. The requirement applies to settlements, judgments, or awards established on or after October 1, 2010. In order to comply with these reporting requirements, covered entities will need to register with the Centers for Medicare and Medicaid Services (CMS) as soon as they become aware of a reportable claim.

Mandatory-Reporting Requirements

Medicare provides healthcare benefits to enrolled beneficiaries, including individuals age 65 and over, individuals with certain disabilities, and individuals with end-stage renal disease. Medicare's obligation to pay for these health care benefits is secondary to that of certain primary payers, including group health plans, liability insurance plans (fully and partially insured), workers' compensation plans, and self-insureds.

A new rule adds Medicare Secondary-Payer Mandatory-Reporting Requirements (MSP Requirements) for certain payments made to Medicare-eligible claimants. The purpose of the reporting requirements is to help CMS determine primary versus secondary payment responsibility, and to recover the costs of those medical expenses for which another entity has primary responsibility.

Responsible Reporting Entities

The law requires primary payers to report to CMS: 1) any payments made to a Medicare beneficiary that include or could potentially include medical payments (referred to as Total Payment Obligation to Claimant or TPOC); or 2) the assumption of ongoing responsibility for medical payments (ORM) to a Medicare beneficiary. The primary payers, responsible for making the report to CMS, are referred to as the Responsible Reporting Entities (RREs). RREs are broadly defined as liability insurers (including EPLI, D&O, and professional liability carriers), no-fault insurers, workers' compensation insurers, and self-insureds.

Reporting Requirements

Even if a claim by a Medicare beneficiary does not involve any medical expenses, an RRE must report the payment to CMS if the release includes claims for medical expenses (e.g., a plaintiff's claim for pain, suffering, and emotional distress).

The requirements apply regardless of whether there was a determination of liability and regardless of any allocation made by the parties or the court. However, CMS will normally defer to an allocation made through a jury verdict or after a hearing on the merits.

RREs that fail to comply with the reporting requirements are subject to a civil penalty of $1,000 per day per incident. In addition, if Medicare has to take legal action to recover a payment to which it is entitled, it may recover up to twice the amount it is due.

Compliance Obligations

Insurers and employers who may be RREs must take the following steps:

Determine whether the claimant is a Medicare beneficiary

The determination of whether the claimant is a Medicare beneficiary must be done before any settlement is reached or any payment is made. Medicare beneficiaries consist generally of those age 65 and older and individuals with certain disabilities or end stage renal disease.

Determine if there is a reportable claim

No reporting is required unless the RRE is obligated to make a payment to a Medicare beneficiary:

- for TPOCs, RREs must report settlements, judgments, awards or other payment, established on or after October 1, 2010, where medical expenses are claimed and/or released;
- RREs must also report ORMs made on or after January 1, 2010 (this typically applies to no-fault and workers' compensation claims); and
- minimums – temporary minimum thresholds for reporting apply for the first 3 years (ranging from $5,000 in 2010 to $600 in 2013).

Determine who is the RRE for the reportable claim

Where the employer is self-insured, either fully or partially, and pays the settlement, judgment, or award, then it will ordinarily be regarded as the primary payer and will be the RRE. If the employer has liability insurance (e.g., EPLI, D&O, or professional liability) and the insurer pays the entire settlement, award or judgment, then the insurer – not the employer – is the primary payer and will be the RRE. Where an employer is self-insured for a deductible, but the payment of that deductible is done through the insurer, the insurer is considered the RRE and will be responsible for including the deductible in the amount it reports as a settlement, judgment, award or other payment.

Registering and reporting

The registration (and testing) process with the CMS may take three months. RREs may register at www.Section111.cms.hhs.gov and should do so as soon as possible in order to begin filing on January 1, 2011. An RRE is not required to register if it has nothing to report; however, RREs must register three months before they have a reasonable expectation of having claims to report. RREs must install required software and pass a testing process before sending actual claims data to CMS.

Mandatory quarterly reporting to CMS begins once registered. An RRE can hire an agent to handle its reporting obligations, but the RRE will still be liable for any failure to report.

Our Advice

First, determine whether your company is an RRE and is required to comply with the MSP Reporting Requirements. If your company is not an RRE, consult with your liability carrier to coordinate reporting requirements with the carrier. If the company is an RRE, register with CMS and identify your Authorized Representative and Account Manager as soon as you become aware of a reportable claim. This is necessary in order to give the company time to install the appropriate software and pass the testing process before paying a settlement, judgment, or award. RREs who are currently defending claims by Medicare beneficiaries should register now.

Next, determine if a claimant is Medicare eligible. For example, during the discovery phase of litigation, ask about the claimant's social security number, date of birth, Medicare eligibility, Health Insurance Claim Number (HICN), and authorization to obtain benefit and claims payment information from Medicare.

Finally, include language in the settlement agreement regarding the MSP Reporting Requirements and indemnification language regarding Medicare reimbursement. If there is a Medicare lien, settle with CMS before paying any settlement, award, judgment, or other payment to a Medicare beneficiary.

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