The Centers for Medicare and Medicaid Services (CMS) recently postponed until next year its requirement that certain employers (who are at least partially self-insured) and liability insurers report to CMS any one-time or lump sum payments to persons entitled to Medicare benefits in connection with settlements, judgments, or awards involving the release of potential liability for medical expenses. Previously, such payments occurring on or after October 1, 2010 were to be reported in the first quarter of 2011. The new deadline requires that payments occurring on or after October 1, 2011 must be reported in the first quarter of 2012.

This extension does not apply to payments made to Medicare beneficiaries pursuant to no-fault insurance or workers' compensation claims. Any payments of that sort occurring on or after October 1, 2010 still must be reported in the first quarter calendar of 2011. Further, CMS has not revised the reporting dates for entities that assume an ongoing responsibility for medical payments.

Background

Medicare is a government-funded health insurance program primarily—but not exclusively—for individuals age 65 or older. However, Medicare is not intended to be the primary insurance coverage for such individuals where there are other funds available to pay for medical treatment (i.e., Medicare is a "secondary payer"). In response to funding concerns for Medicare, Congress passed the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), which former President George W. Bush signed into law on December 29, 2007. See 42 U.S.C. § 1395y(b). The purpose of the Act is to enable Medicare to recover money from beneficiaries who have received payments for medical expenses from third parties. To that end, the law requires an entity that makes such a payment to a beneficiary to report the payment to Medicare.

Who Reports Under the Act?

An entity that is either fully or partially self-insured may be a "Responsible Reporting Entity" (RRE) required to report payments made to a Medicare beneficiary when the payments are for medical benefits or are in exchange for a release that has the effect of waiving claims for medical benefits. For instance, an employer that is not insured, or that has to pay a deductible and/or co-pay on a liability insurance policy, or that pays a portion of a settlement or judgment may be deemed a "self-insured plan" that must report the payment to CMS. (However, if payment to a beneficiary is partially paid by the RRE as part of its deductible, and partially paid by the insurer in the amount exceeding the deductible, then the insurer must report both the deductible and any excess paid beyond the deductible, rather than the RRE.)
What Must Be Reported?

Where an RRE has assumed “Ongoing Responsibility for Medical Benefits” (ORMs), on or after January 1, 2010 (and in some instances even earlier) the assumption and termination of ORMs (not the actual payments) must be reported. That type of payment is not common and typically only applies to no-fault and workers’ compensation claims. One-time or lump sum payments made in situations involving no-fault or workers’ compensation insurance occurring on or after October 1, 2010, however, still must be reported during the first quarter of 2011.

Where the RRE is an employer who is at least partially self insured or is a liability insurer carrier, and it makes a one-time or lump sum payment to resolve all or part of a claim to a person entitled to Medicare benefits, which the CMS refers to as a Total Payment Obligation to Claimant (TPOC), such payments occurring on or after October 1, 2011, must be reported within the first quarter of 2012. This obligation will include circumstances where a settlement or other agreement between an employer and a Medicare-eligible person includes a full release of all claims by the individual. In those cases, any payment occurring on or after October 1, 2011 in exchange for that release must be reported. This will be true even if the individual never asserted any claim for medical benefits, as long as the release would have the effect of releasing any such claim.

Over the next few years, CMS has further limited the obligation to report in cases where the payment is below certain monetary thresholds. Under the most recent guidance, payments made before January 1, 2013 where the TPOC amount is between $0 and $5000 are exempt from reporting. Payments made between January 1, 2013 and December 31, 2013 where the TPOC amount is between $0 and $2,000 are exempt. Payments made between January 1, 2014 and December 31, 2014 with TPOC amounts between $0 and $600 are exempt. There are no thresholds for any TPOC dates on or after January 1, 2015.

Why Is This Important for Employers?

Once the reporting obligation commences, an RRE that fails to report covered payments will be subject to a civil penalty of $1,000 per day per violation. Thus, this additional delay for liability insurers (including self-insured employers) to begin reporting TPOC payments will provide additional time to review the Section 111 regulations and begin the process of registration with CMS if appropriate.

The process of registering with CMS is highly technical and CMS cautions that RREs must begin the registration process a full calendar quarter before the obligation to submit reports arises. This period allows for testing of the technical elements of the reporting process. However, the CMS also has announced a “small reporter” option, which bypasses the testing period for those entities that will submit 500 or fewer claim reports per calendar year.

What Should Employers Do?

- Employers should consult with their insurance carriers and the attorneys handling their insured liability claims to ensure that preparations have been made to determine whether a claimant is a Medicare beneficiary and report information on covered payments in a timely manner.

- Employers should examine their claims history and determine the likelihood of claims or demands generally made against them for medical expenses.
Employers also should consider whether there are other claims for which they would require a full release of all claims in exchange for a settlement payment.

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If “yes,” the employer should consult counsel to discuss registration with CMS to prepare for filing information on covered payments and/or evaluate whether the “small reporter” option is more appropriate.

If “no,” the employer should stay on alert for such claims, and consider registering with CMS in case it is obligated to report a covered payment in the future.

Employers should consult counsel concerning what steps, if any, may be necessary to determine whether a plaintiff or claimant is eligible for Medicare benefits. Because an individual’s Medicare status can change during the course of litigation, such an inquiry should be made at the beginning of the litigation and at the time of a final payment to the claimant, at a minimum. Inquiries about a claimant’s Medicare status can be made (i) to the claimant, (ii) to Medicare’s database (by entities registered with CMS), and/or (iii) to the Social Security Administration.