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New Medicare Secondary Payer Mandatory Reporting Imposes Significant Obligations on Insurers and Employers

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Employers and insurers, heed the good news: We have a three-month implementation delay in the Mandatory Reporting Requirements for Medicare. This is even more important to those who are unaware of the reporting requirements. Two years ago Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), which added new and significant mandatory reporting requirements for group health plans (GHPs) and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation benefits, to report where they have made a payment to a Medicare beneficiary.

With over 78 million American baby-boomers about to age into the system, the intent of the law is to preserve Medicare funds where other insurers are primary to Medicare. The new reporting requirements are being implemented by the Centers for Medicare & Medicaid Services (CMS). All mandatory reporters must register with CMS no later than September 30, 2009; the deadline was originally June 30, 2009.

Many employers will be required to be responsible for reporting, in that they are self-insured for their liability coverage or are considered self-insured under the law based upon the deductible in place for their insurance. While under current law Medicare has been the secondary payer to other insurance for many years, the process has largely been "pay and chase" but with little front-end information to identify the potential sources of such funds. Settlements that covered medical expenses were difficult to identify and track, and beneficiaries were often unable to pay Medicare back when the Medicare Secondary Payer (MSP) issue was identified months or years later.

The penalties for non-compliance with these new obligations are significant - **over $1,000 per day, per claim**. Since the reporting is quarterly and an employer might not realize it had missed a deadline until the next reporting date, it is conceivable that one missed deadline could result in a liability of $90,000 or more. Furthermore, 42 CFR 411.24(i) permits Medicare to recover from the primary payer even if the primary payer has reimbursed the beneficiary or other party if it was aware or should have been aware that Medicare made a conditional primary payment.

Below are the answers to some frequently asked questions that may assist affected parties with compliance.

What are the new obligations for employers and insurers?

MMSEA imposes *registration* and *reporting* requirements.

Employers and insurers who meet the definition of a Responsible Reporting Entity (RRE) are now required to register with Medicare and to report settlements and payouts. RREs (other than GHPs) must register with CMS between May 1 and September 30, 2009.

As of January 1, 2009, GHPs were required to comply with the reporting requirements. All GHPs were required to register not later than April 30, 2009, and recently began testing with CMS.

CMS has been very careful in how they discuss the new mandatory reporting requirements. At almost every opportunity they have explained that the new MSP provisions do not eliminate CMS's existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount information prior to a settlement, judgment, award or other payment.

Who is required to register under the new requirements?

Every employer should engage in a simple process to determine whether it qualifies as an RRE and therefore needs to register with CMS to report under the new MSP requirements.

First, the employer must inventory its insurance coverage to determine if it is an "applicable plan." Applicable plans include liability insurers (including self-insurance), no-fault insurance, and workers' compensation. As every state has different workers' compensation statutes, employers may be faced with an obligation in one state and no obligation in another.

The analysis of whether an employer is an RRE is complex. Examples of liability insurance include, but are not limited to, product liability, auto liability and malpractice liability coverage. Examples of no-fault coverage include medical payment and medical expense coverage as well as any personal injury protection. Employers who have a deductible for their insurance coverage or do not have liability coverage at all must pay close attention: The definition of self-insured may include your company based on the deductible structure and, if you pay for any claims directly (i.e., no liability insurance), you will have to report if a settlement is made with a Medicare beneficiary for anything which has triggered or could trigger a Medicare payment obligation.

When is registration due?

Once an employer makes the determination that it is an RRE, and determines which applicable plans it will need to report, the registration process must begin. Registration must be completed by September 30, 2009.

What does a registered plan need to report?

Reporting is divided into two categories (1) Total Payment Obligations to Claimants (TPOCs) and (2) Ongoing Responsibility for Medicals (ORMs). For TPOCs, the obligation is essentially upon the settlement of the case. For an ORM, the RRE will generally have two reports. The first report is made when the ORM is assumed and the second is made when the ORM is terminated. There are exceptions to reporting; for example, for both liability and no-fault insurance, if the date of incident is prior to December 5, 1980. Most illuminating about this date is the realization that CMS has anticipated that a report could be filed for a claim in which the date of the incident occurred almost 30 years ago. There are also de minimus thresholds for reporting, but they are quite low.

The reporting requirements apply to settlements, judgments and awards made after July 1, 2009 for ORMs and January 1, 2010 for TPOCs. This means that RREs should begin to gather the data they will need to report as they work with any current claims.

When will reporting begin?

CMS expects to test reporting with each RRE beginning July 1, 2009. The RRE will then be assigned a quarterly reporting schedule by which it will be required to report. Each RRE will report once a quarter with all the applicable claims which have occurred in the last 135 days prior to the report. Production reports will be accepted on January 1, 2010, with initial submissions due between April 1 and June 30, 2010, depending upon when the RRE has registered and been assigned a reporting schedule.

This means that RREs need to perform their own due diligence on open cases and any obligations which may exist as of today and how to ensure that any settlements include language recognizing Medicare's interests.