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Litigators Beware: Late Reporting of Payments to Medicare Claimants May Result in Significant Penalties and Double Payments

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If you, like many litigators, saw the word “Medicare” in the title above and were about to hit the “delete” button, please stop and read further—this alert has important information for you.

As their January 1, 2010 effective date approaches, all persons responsible for managing litigation must familiarize themselves with recent amendments to Section 111 of the Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Extension Act of 2007, a provision that imposes reporting requirements on entities paying settlements, judgments, or awards to Medicare beneficiaries.[1] As our anecdotal observations reveal, these new obligations remain foreign to many of those most responsible for compliance—while the penalties for noncompliance are significant. This advisory provides an abridged summary of the dense new requirements and their effect on settlements with Medicare beneficiaries.

Why Should You Read Further?

In all likelihood, the reporting requirements apply to your business, and effective January 1, 2010, Medicare will impose a $1,000 per day civil penalty on any entities that fail to report settlements, judgments, awards, or other payments to Medicare beneficiaries as required. In addition, as explained below, your business could face additional costs.

What is the Purpose of Mandatory Reporting?

Medicare, the nation’s largest health insurance program, covers nearly 40 million Americans. Generally, Medicare covers people of age 65 or older, some disabled people under age 65, and people of all ages with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). When an injured party is a Medicare beneficiary and the date of the incident is on or after December 5, 1980, liability insurance (including self-insurance) and no-fault insurance are “primary payers” to Medicare. In Medicare parlance, Medicare is the Secondary Payer where Medicare is not responsible for paying first. The purpose of Medicare’s reporting obligation is to enable the Centers for Medicare and Medicaid Services (CMS) to determine if Medicare should be acting as a Secondary Payer and to ensure that the

[1] Reporting is also required on claim information where an ongoing responsibility for medical payments exists related to a claim that was assumed on or after July 1, 2009, such as in workers’ compensation payments.

primary payer pays for or reimburses Medicare for Medicare-covered items and services furnished to Medicare beneficiaries.

To What Types of Payments Do the New Requirements Apply?

The reporting requirements apply to any settlement, judgment, or award involving a Medicare beneficiary, regardless of whether the individual asserts a personal injury claim, a toxic tort claim, or even an employment claim (e.g., harassment or discrimination) involving medical expenses.

Who Qualifies as a Responsible Reporting Entity?

Section 111 defines a Responsible Reporting Entity (RRE) to include any entity that is self-insured, certain categories of insured entities, insurers, and employers administering workers' compensation plans. Self-insured entities may designate a Third Party Administrator as a reporting agent. The self-insured RRE however, remains responsible for any penalties assessed for noncompliance. Employers that maintain Employment Practices Liability Insurance (EPLI) and do not pay money directly to claimants are not RREs. Nonetheless, CMS encourages these employers to cooperate with their insurance providers to ensure timely reporting to CMS.

What Triggers a Reporting Obligation?

In general, the following occurrences trigger a reporting obligation: (1) the claimant is a Medicare beneficiary and (2) the claimant has made a claim for medical expenses **or** (3) the claim results in a settlement, judgment, award, or other payment to the Medicare beneficiary that resolves claims for medical expenses. Because Section 111 requires reporting if medical expenses are either *claimed* or *released*, an RRE cannot avoid its reporting obligation by agreeing with the Medicare beneficiary claimant that "no medicals" are being paid. An RRE also may have a reporting obligation where a Medicare-covered claimant executes a general or "blanket" release of all claims (including personal injury claims), despite the fact that the claimant does not have a viable personal injury claim. By contrast, property damage–only claims and business disputes not involving a claim for or the release of medical expenses are **not** reportable.

There is an exception for claims involving an exposure to a substance that occurred and ended prior to December 5, 1980. If there was no exposure of the claimant on or after December 5, 1980 alleged, established, and/or released, then there is no obligation to report the settlement or payment.

How Does an RRE Obtain Information for Reporting?

Section 111 places an affirmative obligation on RREs to determine a claimant's current Medicare beneficiary status. CMS has established a "query access" system to assist RREs in determining whether a claimant is a Medicare beneficiary. CMS will process one inquiry per month per RRE ID, but inquiries may include multiple claimants. RREs will need to provide the claimant's name, Social Security number, date of birth, and gender to perform a query on the CMS system.

Because an RRE may be subject to penalties even if a claimant's Medicare status changes during litigation, it is important for the RRE to keep apprised of the claimant's current beneficiary status. An RRE may consider serving an interrogatory to determine Medicare status. In addition, RREs should contact CMS directly to obtain the claimant's beneficiary status and utilize the form provided by CMS on its website for gathering HICN/SSN and other pertinent data. The CMS form includes a space for

recipients to state that they decline to provide the requested information. An RRE will not be subject to a reporting noncompliance penalty with respect to any individual from whom it collects a signed form at least once every 12 months.

How Does an RRE Make a Report?

The CMS User Guide explaining the logistics of Section 111 reporting is available at http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide2ndRev082009.pdf. The following are a few highlights from the User Guide:

- RREs are required to register with the Coordination of Benefits Contractor (COBC) and fully test the data submission process before submitting production files. RREs will then be assigned a quarterly file submission timeframe during which they are to submit files.
- An RRE must report the full amount of its settlement, judgment, award, or other payment, regardless of any "earmarking" or allocation of the award.
- A confidentiality provision in a release does not exempt an RRE from its reporting obligation. To preserve the confidentiality of reported information, CMS maintains a secure website.
- When multiple defendants are involved in a settlement, judgment, award, or other payment, each RRE involved is responsible for its own separate reporting. If multiple parties enter into one settlement in which the parties are jointly and severally liable for the entire payment, then each party must report the total settlement amount.
- While some RREs have outsourced their reporting to an agent, they cannot shift the reporting responsibility to the agent (e.g., by contract). Because an RRE is ultimately responsible for complying with Section 111, it will need to work with its agent to develop a method to verify the accuracy of any reporting by an agent. An RRE that outsources reporting may seek to negotiate for indemnification by its agent.
- Ongoing Responsibility for Medicals (ORM) refers to the RRE's responsibility to pay on an ongoing basis for the Medicare beneficiary's medicals associated with the claim. Typically, this will apply to workers' compensation and no-fault compensation claims. RREs must report ORM without regard to whether there also has been a separate settlement, judgment, award, or other payment in addition to the ORM. For claims where the injured party is a Medicare beneficiary and there has been a settlement, judgment, award, or other payment, and the RRE has not assumed ORM, only one report is required. For claims where there is no settlement, judgment, award, or other payment, but the RRE has assumed ORM, two reports are required, the first upon assumption of the ORM, and the second upon termination of the ORM.

When Must a Report Be Filed?

RREs must report "once there has been a settlement, judgment, award or other payment." The actual electronic data submission process will take place between the RREs and the COBC during the quarterly file submission timeframe (a seven-day window) assigned by CMS. Quarterly file submissions should include new or changed claim information and resubmissions of records found in error on a previous submission. CMS will not accept interim file submissions. Reports must include the claimant's Social Security number, along with other detailed information about the claimant, the injury, and the payment.

CMS-established testing periods are currently under way to help RREs transition into the reporting process before the period where penalties can be assessed for untimely reporting. The testing period for

query input files began on July 1, 2009 and continues until March 31, 2010. The testing period for claim input files is from January 1, 2010 through March 31, 2010. CMS is providing free computer-based training during the testing periods. RREs are required to begin live production submission no later than their assigned submission window in the second quarter of 2010.

How Will These Changes Impact Settlements?

In light of the new mandatory reporting requirements, companies must establish protocols (i) to collect Medicare information from claimants and CMS to determine whether a claimant is a Medicare beneficiary and (ii) to report settlements paid to Medicare beneficiaries in a timely manner. A completed and verified Medicare Mandatory Reporting Information Form should be made a prerequisite to any settlement.

Where applicable, settlement and release agreements should specify that the claimant did not assert a claim for medical expenses and that the release does not have the effect of releasing medical expenses. In addition, where applicable, settlement agreements should include an acknowledgment of Medicare's interests, an attestation of the claimant's Medicare beneficiary status, and a description of steps taken to protect Medicare's interest.

Settlements also may provide for direct payment to Medicare or a set aside to ensure that CMS recovers medical costs for any settling Medicare beneficiary within 60 days of a settlement payment. One possible approach is for an RRE to make distribution of settlement proceeds contingent upon payment in satisfaction of a demand for reimbursement issued by Medicare. Entities settling claims with multiple Medicare beneficiary claimants also should structure the settlement so that the RRE receives notice of the exact settlement amount paid to each Medicare beneficiary for reporting purposes.

Are There Other Potential Penalties Beyond $1,000 Per Day?

Yes. If the Medicare beneficiary does not repay Medicare within 60 days from the receipt of the settlement or judgment, your business may be required to pay amounts due and owing to Medicare—essentially doubling the payment for the allocated value of any medical claim.

CMS is expected to issue further guidance, including regulations, concerning the Section 111 mandatory reporting obligations in the near future. We will provide additional information if and when that should occur. In the meantime, Morgan Lewis can help your company develop a system to facilitate compliance with the new reporting requirements, including designing agreements, practices, and procedures to accurately identify events that trigger reporting obligations and to avoid being assessed monetary penalties.

If you have any questions or would like more information about any of the issues discussed in this LawFlash, please speak with a member of the firm's Labor and Employment Practice or Litigation Practice, or with the following Morgan Lewis attorneys:

Labor and Employment		
Princeton		
Richard G. Rosenblatt	609.919.6609	rrosenblatt@morganlewis.com
Litigation		
Philadelphia		
Thomas J. Sullivan	215.963.5146	tsullivan@morganlewis.com
FDA/Healthcare Regulation		
Washington, D.C.		
Joyce A. Cowan	202.739.5373	jcowan@morganlewis.com
Employee Benefits		
Chicago		
Andy R. Anderson	312.324.1177	aanderson@morganlewis.com
Sage Fattahian	312.324.1744	sfattahian@morganlewis.com

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