In December of 2007, a law was enacted which established new requirements for liability insurers to report any claims paid to a Medicare beneficiary. Since that time, the PIAA has worked closely with officials from the Centers for Medicare and Medicaid Services (CMS) to clarify these requirements and to limit the repercussions for medical professional liability insurers. This document is provided to help answer some of the questions and concerns insurers currently have about this requirement.

**Who must report?**
The law requires all “applicable plans” (defined as liability insurance, no fault insurance, workers compensation plans, and the self-insured), referred to as “responsible reporting entities” or RREs to report all required information.

**What must be reported?**
Information must be given to CMS on any payment made to a Medicare beneficiary (or those who file suit on behalf of a deceased Medicare beneficiary) by an “applicable plan.” The required information includes information about the beneficiary, about the insurance policy from which the payment was made, and about the insurer itself.

**When does the law become effective?**
The law officially took effect on 7/1/2009, however, due to implementation delays most medical liability insurers will not begin reporting until 1/1/2012 (see below for more details).

**When must reports be filed?**
An RRE must report ORM (Ongoing Responsibility for Medicals, i.e. continuing direct payments from the RRE) obligations during their designated reporting period beginning after 1/1/2011. Liability insurer RREs (including medical professional liability insurers) do not need to report TPOC (Total Payment Obligation to the Claimant, i.e a one-time payment) obligations involving a Medicare beneficiary until their designated reporting period beginning 1/1/2012. Only TPOC obligations reached on or after 10/1/2011 will need to be reported.

**Do we report all claims filed against any of our policy holders?**
No. CMS is only requiring a report to be filed if a settlement agreement or judicial decision establishes a payment obligation to a Medicare beneficiary (or a claimant who sued on behalf of a deceased Medicare beneficiary). It does not apply to payments made to a claimant who was not a Medicare beneficiary at the time of the alleged incident and is not a Medicare beneficiary at the time of the settlement or verdict.
Do we report beneficiaries of Medicaid or SCHIP?
No. The law only requires reports to be made when the claimant is a Medicare beneficiary.

Do we report only payments for medical expenses?
No. The full amount of any payment made to a Medicare beneficiary claimant must be reported, regardless of how the payment was divided between various types of economic and non-economic damages. While CMS generally defers to the court’s allocation if there is a full hearing on the merits, it is not bound by any allocation made by parties to a settlement.

Do we make payments to Medicare when we report the claim?
No. CMS is focused solely on collecting information at this time. We have been informed that they intend to focus any collection activities on claimants after they have received payment, and therefore the simplest thing to do is to pay the claimant in full. While CMS does review Medicare Set-Asides in workers compensation claims, they are trying to deter (at this point) Set-Asides for liability claims by refusing to guarantee the sufficiency of any Set-Aside for future medical expenses. [It should be noted that previously existing law allows CMS to seek payments from insurers, even if the claimant was paid in full for their damages. CMS has stated that it does not intend to use this avenue to collect funds, however, PIAA remains concerned about possible “double” payments being collected from insurers and is seeking ways to prevent this occurrence.]

Is there a way to prevent CMS from coming after the insurer if the damages paid to the claimant include the full cost of medical expenses already paid by Medicare?
Not really. Even if a settlement agreement includes language indemnifying the insurer from any Medicare liabilities, Medicare is not obligated to abide by that agreement. CMS suggests making all checks to Medicare beneficiaries out to both the beneficiary and to Medicare. The industry has expressed concern about this and discussions about this matter are ongoing.

What about penalties for failure to report?
The law allows CMS to issue a penalty of $1,000/day for each report that is not filed. CMS officials inform us, however, that they do not intend to issue fines to anyone who is making a good faith effort to be in compliance.

If a payment includes future damages, what is the reporting requirement for insurers?
That will depend on the nature of the payments made. If a structured settlement requires the insurer to make ongoing payments (ORM) to the beneficiary, the insurer will have to report that information and note when the payments begin. It will then have to report again when the payments cease. If the structured settlement involves an annuity, however, CMS considers the purchase of an annuity to be a one-time lump sum payment (TPOC) to the beneficiary. An insurer would then only need to report once, when the settlement is reached. In reporting the amount of annuity, an insurer is to use the larger value of either the minimum payout amount or the anticipated payout using the estimated time period for payouts used to calculate the purchase price of the annuity.

When are we required to report?
Reports must be filed quarterly (with exceptions for Direct Data Entry reporters – see below), based on a schedule to be assigned to the insurer by Medicare. Insurers must report any settlement or verdict resulting in payment which was reached during the previous quarter. If a settlement or verdict is reached within 45 days of the file submission period, however, it does not have to be reported until the following quarter in order to give the insurer sufficient time to process the required information.
What if future damages are ordered which will extend far enough into the future that the claimant will become Medicare eligible while receiving those payments?
If the insurer continues to make payments once the claimant has become a Medicare beneficiary, a report would have to be filed. As stated previously, however, if the claim was paid via an annuity, and the claimant was not a Medicare beneficiary at the time of the settlement/verdict, CMS does not consider that to be an ongoing payment (since the additional payments are not coming from the insurer itself), and therefore no report is required.

When is a report due if a verdict for the claimant is appealed?
If a verdict is appealed, but payments have started nonetheless, the report is due during the next reporting period. If a verdict is appealed and no payments are being made until conclusion of the appeal, the report is not due until the reporting period following the completion of the appeal process.

Is there a reporting floor?
For liability insurers, a threshold reporting scale has been established. Through 12/31/2012, no claims equal to or less than $5,000 need be reported. Subsequently, the threshold amount will be set at $2,000 for claims which are finalized in 2013 and $600 for claims completed in 2014. No threshold will be in effect for 2015 and beyond.

How is the insurer to know if the claimant is a Medicare beneficiary?
CMS will allow insurers to make queries of the CMS database once per month in an effort to determine if a claimant is a Medicare beneficiary. In order to make the query, the insurer will need the claimant’s full name, date of birth, gender and Social Security Number or Health Insurance Claim Number. It should be noted that the query function is not infallible and insurers should consider additional efforts to obtain information about the claimant’s Medicare status directly from the claimant.

Is there another reporting option for companies that will only have a limited number of claims to report annually?
Yes. Medicare has established a Direct Data Entry (DDE) option for low volume (500 claims or less per year) reporters. If registered for this option, an RRE will enter required claim data directly into a secure CMS website within 45 days of the payment obligation being finalized. Reports will, therefore, be done as payment obligations are incurred rather than quarterly. Entities using the DDE option will not be eligible to query Medicare about a possible beneficiary’s status, so keep that in mind before choosing the DDE option.

How are insurers supposed to get the claimant’s Social Security Number?
The law requires a Medicare beneficiary to comply with efforts by CMS to collect funds owed to the government. It is not clear, however, if this applies to private insurers attempting to comply with the reporting requirement. CMS has developed a form (available on its website) which it believes may be helpful in collecting the SSN from a claimant. It is also examining other ways to help insurers collect the required information.

What other information is available to help insurers prepare for compliance?
All information pertaining to the reporting requirement is available at [http://www.cms.hhs.gov/MandatoryInsRep/](http://www.cms.hhs.gov/MandatoryInsRep/). Currently, the website includes a “User Guide” (which is updated as needed), as well as information sheets and transcripts of teleconferences discussing the requirements.
What should insurers be doing to ensure they are compliant?
By now, all companies should be registered as RREs. When a claim is filed, the company should attempt to promptly determine if the claimant is a Medicare beneficiary (or if the claim is being filed on behalf of a Medicare beneficiary). If the claimant is, it is in the company’s interest to notify Medicare promptly so that Medicare may begin determining what amounts, if any, it will be owed (this may simplify the settlement process by giving Medicare sufficient time to make all necessary calculations in the event the plaintiff’s attorney does not notify Medicare about the claim. The company should also make all reasonable efforts to obtain the required data, and document any inability to collect information from the claimant. In addition, all company’s should continue to participate in town hall teleconferences with CMS, and monitor the CMS website for new guidance or changes to the User Guide (because this program is controlled by guidance, rather than regulation, changes to the guidance may be made at any time with little or no notice to the public).

If you have additional questions about the Mandatory Reporting Requirement, please contact Mike Stinson, PIAA Director of Government Relations at (240) 813-6139 or mstinson@piaa.us.