INTRODUCTION

Recent changes in federal law represent a sea change in the consideration that must be given by defendants to the interests of Medicare. Up until March, 2009, Medicare, when attempting to recover past payments made to beneficiaries, was severely handicapped by a lack of specific information concerning legal settlements pertaining to injuries and illnesses that had resulted in the payment of the Medicare benefits. Effective January 1, 2011, insurers and self-insureds, denoted as "Responsible Reporting Entities" or "RREs," are obligated to report very specific details of personal injury settlements and judgments in excess of $5000, in order to allow Medicare to assert its right to recover *past* payments from its beneficiaries. Additionally, the reporting requirements imposed allow for possible recovery of *future* medical expenses incurred post-settlement or post-judgment. Severe penalties for non-reporting and for failure to properly report settlements and verdicts can be imposed against insurers and self-insureds (RREs).

Currently, the federal government is having a no small difficulty explaining the implementation of the reporting requirements and answering practical questions concerning the obligations of the reporting entities. The starting date for the formal reporting requirement has been moved at least three times to the current date of January 1, 2011.[1] In recent conference calls regarding details of the program, government participants have been repeatedly stumped by seemingly obvious questions and concerns raised by callers. The answers to many important questions are often unavailable and presently unknowable. To remain current, insurers and self-insureds must monitor the website of the Centers of Medicare and Medicaid Services:

www.cms.hhs.gov/MandatoryInsRep/01_Overview.asp

---

[1] The January 1, 2011 date requires reporting of payment events occurring on or after October 1, 2010.

2.

MEDICARE, A SHORT HISTORY

The Medicare Program came into existence as one of Lyndon Johnson's "Great Society" programs. The Social Security Act of 1965 established Medicare as a federal health insurance program for persons over 65 and individuals meeting certain other program requirements. The Medicare program is administered by the Centers for Medicare and Medicaid Services ("CMS"), a bureau of the Department of Health and Human Services.

Between 1965 and 1980, the Medicare program was the primary payer for medical bills and expenses of beneficiaries in all cases except those involving workers' compensation. In 1980, in response to rising costs, Congress passed the Medicare Secondary Payer Act ("the MSP"), which prevents Medicare from paying for medical expenses in circumstances where another entity had a legal or contractual obligation to pay for the same medical treatment. By federal statute, Medicare was thus transformed into a payer of last resort – a secondary insurance plan that may pay for medical treatment subject to reimbursement by a primary source. Primary sources include private insurers, self-insureds or third party tortfeasors. In all situations where another entity is required to pay for covered services, that entity must pay before Medicare does, and must do so without regard to a patient's Medicare eligibility.

In 2007, Congress passed the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"). The Act imposes mandatory reporting requirements on insurers and self-insureds. The requirements of the MMSEA are the main subject of the following discussion.

3.

MEDICARE ELIGIBILITY

It is essential to understand who, exactly, might be a Medicare beneficiary. This is critically important since the beneficiary status of the claimant or plaintiff triggers the requirement that settlements and judgments be reported to the CMS. Where it is known that a claimant received Medicare payments for an injury or condition at issue in the litigation or claim, the obligation to take Medicare's reimbursement interests into account presently exists.

In general, persons over age 65 are *eligible* to receive Medicare benefits. This does not necessarily mean that such a person *actually received* any benefits from Medicare for an injury or illness related to the litigation. The Code of Federal Regulations currently defines a beneficiary as "a person who is *entitled* to receive benefits" and also as "[an individual who] *meets* all of the requirements for Medicare benefits."[2] A person over the age of 65 might not have made a claim to Medicare for injuries involved in the claim or suit, due to the existence of private insurance or for some other reason. The failure of the claimant to make a claim to Medicare for an injury or illness, or to even sign up for Medicare in the first instance, does not make the claimant ineligible to receive Medicare benefits. If the person otherwise qualifies, they are still considered Medicare eligible and, by definition, a beneficiary. In other words, a Medicare beneficiary may not have received anything at all from Medicare, but the duty to report still exists.

A person aged 65 or older is highly likely Medicare eligible and a beneficiary. Simple reliance on the claimant's age of less than 65 is, unfortunately, not enough to rule out the possibility of the plaintiff or claimant being a Medicare beneficiary, because there are exceptions to the requirement that a beneficiary be at least age 65. In addition to

---

[2] 42 CFR 400.202 and 400.202(3), emphasis added.

some extremely serious medical conditions such as total kidney failure, a very significant exception to the age 65 requirement is one that authorizes benefits for anyone of any age receiving *Social Security* disability benefits for a period of at least 24 months. In other words, a very young person who is severely disabled and receiving Social Security disability benefits could well be a Medicare beneficiary, triggering the reporting requirement.[3]

In general, the following should be taken as strong indicators that a claimant or plaintiff is a Medicare beneficiary:

A. Claimant is at least age 65;

B. Claimant of any age is severely disabled and possibly receiving Social Security disability benefits;

C. Claimant of any age has end stage renal disease;

D. Claimant of any age has Lou Gehrig's Disease.

The CMS does not require insurers and self-insureds (RREs) to rely on a claimant's representations -- or their own guess work – to determine whether a particular claimant is, in fact, a Medicare beneficiary. To assist in the identification process, a monthly query may be made of the CMS's Coordination of Benefits Contractor ("COBC") to determine the Medicare status of the claimant. The query request must include the Social Security Number ("SSN"), name, gender, and date of birth of the injured party. A query can also be made using the injured party's Health Insurance Claim Number ("HICN"), although the assignment of such a number to the injured party prior to the request is very strong indicator that the claimant may have received Medicare benefits.[4] An HICN is typically the claimant's SSN with the addition of a single letter suffix. RREs must implement a procedure in their claims review process to determine

---

[3] And, again, if the person is eligible but not actually receiving anything, the person is a beneficiary.

[4] At a minimum, it indicates that the claimant has registered to receive benefits.

whether an injured party is a Medicare beneficiary and to gather the information necessary for Section 111 reporting.

4.

CONDITIONAL PAYMENTS

The phrase "conditional payments" is frequently used by the CMS. The term has confused many people who do not understand the 'secondary payer' aspect of Medicare as a result of the changes occurring in 1980. After 1980, payments made by Medicare are always subject to recovery from primary payers. In that sense, Medicare considers all its payments "conditional" because, if a primary payer (insurer or tortfeasor) can be found, Medicare can seek to recover its prior payments made to the beneficiary. For some, conditional payments may be more easily understood as simply amounts Medicare has paid for treatment of an injury *before* judgment or settlement. To make it easier still, conditional payments are essentially past medicals.

Since 1980, Medicare has had a right to recover conditional payments from primary payers, including tortfeasors and liability insurers. However, there was no effective, enforceable reporting mechanism that assisted Medicare in identifying primary payers and discovering details of settlements and judgments. Medicare could only rely on voluntary disclosures made by the beneficiary or beneficiary's attorney.[5] As a result, Medicare failed to recover conditional payments because the CMS was unaware that a primary payer existed. Often, Medicare would also pay for post-settlement treatment despite the fact that recovery was made on a claim that included damages for future medical treatment. In that sense, the claimant had been compensated for foreseeable future medical treatment in the settlement or verdict and would then also receive Medicare benefits when treatment was eventually provided. As a result, Medicare both failed to recover conditional payments made for past treatment and made payments for

[5] Think of where the Internal Revenue Service would be without employer-filed W2's.

future treatment it never should have, because it had no knowledge of the primary payer making payment intended to include that eventual treatment.

5.

THE MMSEA (2007)

Again prompted by growing program costs, Medicare sought to identify benefit-related litigation or benefit-related primary payers and to aggressively pursue recovery of conditional (pre-settlement or pre-judgment) payments for medical care. The mandatory reporting requirements in the MMSEA take matters a step further, however, and allow Medicare, armed with settlement details, to protect its interests as to post-settlement, post-judgment (future) medical expenses for an injury or condition that was the basis for a claim. On the specifics of how a settling defendant can properly respect Medicare's rights with respect to future payments to the beneficiary, the CMS remains maddeningly ambiguous and indecisive.

Before addressing the reporting requirements of the MMSEA, practical details of which are still being invented and revised by the federal government, it is important to understand that the obligation of a defendant to take Medicare's reimbursement interests into account in a settlement *presently exists*, despite the fact that the mechanism for reporting details of a settlement or judgment remains very much a work in progress. In other words, defendants should *now* be checking to determine whether a claimant is a Medicare beneficiary and requiring, at a *minimum*, that a claimant reimburse Medicare for any conditional payments as a provision of any settlement agreement. Where a settlement is being made with a known or verified Medicare beneficiary, adding Medicare as a payee on the settlement draft is currently prudent.

Section 111 of the MMSEA added two short, but powerful, sections to the MSP. One imposes a specific, mandatory reporting requirement on those entities considered primary payers of medical benefits and names such entities Responsible Reporting Entities or "RREs." RREs are primarily insurers and self-insured entities. The new

mandatory reporting requirements, by timing and substance, provide Medicare with timely and detailed information that will enable it to more readily recover conditional payments for pre-settlement or pre-verdict medical care rendered to a Medicare beneficiary. The new information may also alert Medicare to compensation to a claimant that included some component for future medical treatment, thereby allowing Medicare to refuse payment for that treatment on the grounds that a primary payer has previously compensated the beneficiary for it. In some circumstances, particularly where Medicare makes a future payment and then later pairs that payment data with a previously reported settlement, Medicare may seek recovery from its beneficiary *and/or the settling defendant; including the insurer and the insured.*[6] The situation concerning future medicals (in other words, post-settlement payments) by Medicare for an injury that was the subject of a settlement is presently quite murky and will be covered under its own heading, below.

The second addition to the MSP encourages RREs to make the new reports by providing for substantial penalties for failure to make timely reports required by the Section 111.

6.

REPORTING REQUIREMENTS

- Who Must Report?

As indicated above, starting January 1, 2011, with respect to settlements or judgments occurring on or after October 1, 2010, insurers and self-insureds (RREs) must report settlements and judgments relating to Medicare beneficiaries. In the words of the CMS, an RRE is generally the entity that makes any payment for bodily or personal

[6] See later discussion of *US v. Stricker*, a civil action recently filed against beneficiaries, insureds, insurers, and beneficiaries' (plaintiffs') counsel, for recovery of past conditional payments, among other things.

injury involving a Medicare beneficiary. Such a payment may be partial, or in connection with a settlement, judgment, or award.

A third party administrator ("TPA") which merely issues the check is not an RRE. If a company is fully insured, the insurer is the RRE. If a company has some form of a risk retention program or plan, such as a high deductible policy or a self-insured retention ("SIR"), the company may be the RRE at least to the extent of the deductible or retention. The CMS had made some contradictory statements that could lead an entity that was uninsured for the full amount of a judgment, award or settlement to believe that it was not under an obligation to report. In its latest Alert on February 24, 2010, concerning "WHO MUST REPORT," CMS attempts to clarify the situation; entities with a deductible insurance plan no longer meet the definition of an RRE, even if the entity pays the deductible directly to the claimant. In any deductible scenario, the insurer is the RRE for reporting purposes and must include the deductible amount in any total payments it reports. However, the Alert also points out that if the insured entity acts without recourse to its insurance in resolving a case, the insured is the RRE whether it settles the case below or above its deductible.

With respect to self insureds with excess coverage, the identity of the RRE depends on whether the excess insurer reimburses the self insured entity or pays the claimant directly. If the excess insurer pays the claimant, it is the RRE; otherwise the self insured entity is the RRE and must report the total payment. The February 24, 2010 Alert from CMS sets forth additional rules for determining who is an RRE in various circumstances.

If a company is the RRE for some claims and uses a TPA to administer those claims, the company may contract with the TPA to act as the company's agent in reporting the required data to Medicare. However, Medicare will hold the RRE accountable, not the agent, if a problem with reporting occurs. The RRE is responsible for the accuracy of the reporting and for any fines for failure to timely report a claim

payment to Medicare in accordance with Section 111 reporting requirements. Any contractual agreement between the RRE and TPA should reflect the cost of the reporting function and who will be responsible for any fines for untimely reporting.

The important thing from the CMS's perspective is that the settlement or judgment gets reported. If an insured with a high deductible does not have written confirmation from its insurer that the claim has been reported, it should do so itself.[7] This is true even where the settlement or judgment was paid with no contribution from an insurer. From Medicare's perspective, the information that matters is the existence of a primary payer and the details of the payment. Medicare's interest in recovering payments is the same whether the primary payer is an insurer or not.

♦ Triggering The Reporting Requirement

As of February, 2010, CMS has delayed the first required production data submission by any RRE until January 1, 2011. For liability insurance policies, any kind of payment, subject to the limited thresholds set forth below, made to a Medicare beneficiary on or after October 1, 2010, for a claim or potential claim of personal injury, is considered a payment that triggers a reporting requirement under Section 111. Claims settled before October 1, 2010, do not have to be reported. Also claims with Ongoing Responsibility for Medicals ("ORM")[8] as of January 1, 2010, are reportable in any amount under Section 111. Claims with ORM closed administratively before this date are not required to be reported.

In response to requests by the insurance industry, in March, 2009, the CMS announced thresholds below which claims did not have to be reported. In connection

---

[7] As discussed below, a carrier and an insured may have different reporting schedules as a part of the registration process.

[8] "Ongoing Responsibility for Medicals" or "ORM" refers to the RRE's responsibility to pay on an ongoing basis of for the injured party's (Medicare beneficiary's) medicals associated with the claim; and typically, ORM only applies in no-fault and worker's compensation claims.

with delay of the initial reporting date, CMS also extended the threshold dates. Note, however, that important distinctions are made for claims involving a payment, labeled a "TPOC" (Total Payment Obligation to Claimant), associated with a settlement, judgment, or award, and a claim involving ORM after January 1, 2010, (the latter are all reportable). RREs and their attorneys should review CMS guidelines on this topic closely. There are also special exclusions for cases with ORM and thresholds for cases closed through settlement, judgment, or award, as illustrated by the following guidelines. Remember, as a general rule, where there is no settlement, judgment, award, or other payment, including no assumption of ORM, there is no Section 111 report required, until such an event occurs. Making a query to find out if a claimant is a Medicare beneficiary is not the same thing as reporting a settlement or judgment.

> Reportable Events (Cases Involving Medicare Beneficiaries)

- Cases with ORM[9] as of January 1, 2010;
- Cases with a TPOC calculated after settlement, judgment, or award, on or after October 1, 2010:

> Excluded Events and Thresholds

- Contested Cases Exclusion: No ORM and no payments have been made to or for the benefit of the claimant (only excluded until settlement, judgment, or award occurs or appeal resolved).[10]

---

[9] The duty to report ORM is triggered when the RRE determines to assume responsibility for ORM, not when payment is actually made. In fact, ORM dollar amounts are not reported, just the fact that ORM exists. When ORM ends (a no-fault limit is reached, the injured worker is healed, back to work and the RRE no longer has ORM, etc.) then the RRE reports an ORM termination date. If there was no TPOC for a settlement, judgments, award, or other payment related to the claim, the RRE may never need to report a TPOC amount on a claim with ORM (only the termination date for the ORM).

> Total Payment Obligation to Claimant (TPOC) Thresholds[11]

- TPOC amounts $5,000.00 or less not reportable between January 1, 2011 and December 31, 2011;
- TPOC amounts $2,000.00 or less not reportable between January 1, 2012 and December 31, 2012;
- TPOC amounts $600.00 or less not reportable between January 1, 2013 and December 31, 2013;
- All TPOC amounts reportable after January 1, 2014;
- Limited to workers' compensation and liability claims.

There are other exclusions for workers' compensation ("WC") claims not considered here. Also, with respect to exposure claims (asbestos and the like), when the last known exposure precedes December 5, 1980, such claims do not have to be reported.

♦ What Is a Timely Report?

Subject to the excluded events and thresholds set forth above, claim payments are reported when a Medicare beneficiary receives partial payment (or when payments are

---

[10] If a judgment or award is appealed and no payments are being made, any TPOC or ORM is not reportable until the appeal is resolved. If payments are being made during the appeal process, report the TPOC or ORM. (User Guide Version 3.0, February 22, 2010, section 11.10.2, p. 88).

[11] If prior payments have been made in the same claim prior to October 1, 2010, they should be totaled with any TPOC paid on or after that date to determine the threshold value for reporting purposes.

made on behalf of the beneficiary), or when a settlement, judgment, or award (TPOC) is reached, without regard to liability.[12]

Under the CMS guidelines, reports are transmitted quarterly during a 7 day file submission window assigned to each RRE as part of the certification process. There is one such seven day window per quarter. There is a grace period if the settlement, judgment, award, or other payment is made within 45 days prior to the start of the 7-day reporting window. In that event the RRE (or its agent) may report that payment in the following quarterly reporting window. The parties reach a TPOC when an agreement is signed, or where court approval is required, when the parties receive that approval. Actual payment is not required before making a report. If a payment is made without an agreement, the reporting obligation is triggered so long as the TPOC threshold is exceeded.

CMS requires submissions of many of data elements for each claim that meets CMS's reporting criteria.[13] Many of the data fields are not currently being used during the testing phase for reporters. As noted above, Section 111 reporting requirements that were originally scheduled to go into effect April 1, 2010, have now been extended. The time period between April 1, 2010, and December 31, 2010, will be used to continue testing the data transmission system between RREs and the CMS. RREs must begin submitting actual data to CMS on January 1, 2011. RREs that have completed registration and testing may begin submitting production data during their assigned submission period beginning in the second quarter of 2010 (April 1 to June 30), but no earlier.

---

[12] As discussed elsewhere, Medicare's statutory right to recover its conditional payments for the same injury which it deems as overpayments only arises when a payment is made or a TPOC is reached.

[13] See, Appendix A – Claim Input File Layout, User Guide, Version 3.0, February 22, 2010, pp. 121-160.

7.

FUTURE PAYMENTS

It is clear that the CMS desires to make sure that a claimant is not both compensated in a settlement or judgment for anticipated future medical expenses, and also able to ultimately have Medicare pick up those same expenses when treatment is rendered. The manner by which Medicare will ultimately accomplish this is uncertain, and specific questions in this area, in particular, prompt "we'll get back to you" responses from the CMS. What is particularly troubling at this stage in the evolution of the CMS's directives is the uncertainty, and present impossibility, of ensuring that CMS will ultimately accept the manner in which the RRE handled a portion of a settlement or judgment that compensates a claimant for future medical expenses.

At this point, the CMS requires settling defendants to give "reasonable consideration" to Medicare's interests in connection with a settlement. There are no clear guidelines (and certainly no bright lines) on what the CMS considers "reasonable." Equally troubling is the lack of meaningful guidance on the nature of the "consideration" required. There is presently no mechanism for obtaining approval of any particular attempt to 'reasonably consider' Medicare's interests. Medicare has indicated it would consider a jury verdict that specifically quantifies future medical damages binding – otherwise it is not bound to accept an allocation. In other words, an agreement that sets forth a specific allocation to future medical expenses is not unhelpful, but is also not binding or conclusive on Medicare.

It seems clear at this point that settlement documentation with a Medicare beneficiary or someone likely to be a beneficiary in the near future[14] should expressly state:

---

[14] A beneficiary in the near future? How near? This is unknown. If expenses are ongoing or expected in the future when the claimant is a Medicare beneficiary, then Medicare's future interests should be addressed in the settlement.

A. That that the settling parties have considered Medicare's future interests and have sought to protect them;

B. That it is not the intention of the parties to shift to Medicare responsibility for treatment for injuries or illnesses that are the subject of the litigation;

C. That there has been an allocation of the settlement proceeds to be set aside for payment of anticipated future medical expenses without resort to Medicare [preferably the allocation will be spelled out in the agreement and it will have some reasonable relation to the medical records and opinions of experts];

D. That the claimant understands that Medicare will require the claimant to pay future medical expenses for the injury or illness from the set aside proceeds of the settlement and that the claimant will keep that portion of the settlement proceeds separate and will use it only for that purpose;

E. That the claimant understands that the settlement could adversely affect future proceeds from Medicare for injuries and goes forward with the settlement with that risk in mind.

Even if a claimant has not received any Medicare benefits by the time of a settlement, the best practice would be to report the settlement to CMS if there is anticipated future treatment that might occur when the claimant is Medicare eligible.

If the claimant is not Medicare eligible and no future treatment is anticipated that might occur after the claimant becomes Medicare eligible, the settlement does not need to be reported. If there is no reason to believe that a claimant might be a Medicare beneficiary, then a settlement agreement should require them to confirm that fact. It would also be wise to cover the point in deposition, interrogatories, or requests for admission.

8.

PENALTIES

The penalty for failing to report a claim is $1000 per day, per claim. That does not seem terribly egregious until one considers what could happen if the report is more than 7 days late. The RRE would have missed its quarterly window to report, and *cannot* report the claim until the next one. The $1000 penalty could become a nearly $90,000 penalty, per claim, even if the error is promptly detected and the RRE attempts to comply, but cannot.

The $1000 per day penalty, unfortunately, is not the sole adverse consequence that could result. The failure to consider Medicare's right to reimbursement of conditional (past) payments could lead to other penalties. If the claimant and/or the plaintiff's attorney does not honor Medicare's demand to be reimbursed for its conditional payments, Medicare can seek reimbursement from the claimant, the claimant's attorney, *the defendant, and its insurer*.[15] If the ratio of the settlement or judgment amount to the medical expenses paid by Medicare is high, a defendant *could end up essentially paying the settlement twice*. If the claim is not satisfied despite a demand and Medicare (the CMS) has to take legal action, CMS "may recover twice the amount" of the conditional payments. 42 *C.F.R.* section 411.24(c)(2). The statute provides that CSM has a direct right of action against any primary payer. Section 411.24(e). The section also provides that "CMS has a right of action to recover its payment from any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment." Section 411.24(g).

With respect to conditional (past payments), a settling defendant should require the plaintiff beneficiary to settle Medicare's claims at the same time, and put Medicare on the settlement draft. Such a step would preclude a meritorious Medicare claim against an

---

[15] See discussion of *US v. Stricker*, below.

RRE for those payments. As to future payments, CMS refuses to be specific concerning what an RRE should do to protect itself and make sure that a closed file is truly closed. The specific amount of a settlement allocation in the agreement as to future medicals must be reasonable and defensible in the event of a Medicare challenge. The claimant and the claimant's attorney will be motivated, of course, to make any set aside as small as possible, despite their extravagant claims for future medical expenses alleged during the course of the litigation. The claimant will, obviously, also be sorely tempted not to set aside that allocated portion of the settlement and rather to spend it. The allocation is subject to negotiation, but there is no present mechanism to prevent a claimant from commingling the set-aside and/or spending it. The CMS is being asked to address this uncertainty through a safe harbor provision and/or a statute of limitations to protect RREs who make payments with an agreement from the claimant to respect Medicare's rights.[16]

9.

UNANSWERED QUESTIONS AND UNINTENDED CONSEQUENCES

It is going to become more difficult to settle cases. With respect to future Medicare payments, we do not presently know what specific conduct the CMS will consider a "reasonable consideration" of its benefits. A settling defendant cannot currently guarantee that settlement proceeds allocated to future medical expenses will in fact be held and preserved for that purpose after the settlement.

If Medicare is slow to pair up its data report from the RRE with the eventual medical bills for litigation or claim related injury, it will likely have paid the bills and will be seeking reimbursement from its beneficiary. If the beneficiary cannot repay Medicare, the CMS will determine whether the settling defendant "reasonably considered" its interests. The inquiry, at that point, would be fundamentally self-serving. The lack of any mechanism to obtain contemporaneous approval of the steps taken to

---

[16] See discussion in Conclusion and Exhibit "A" concerning very recent proposed legislation.

protect Medicare's interests as to future payments, together with the CMS's failure to provide meaningful guidelines on this point, makes it more difficult in many cases for a defendant to "buy its peace" by settling the case. The potential exposure, as noted early, could be the equivalent of paying the claim again. Even a victory in an appeal of Medicare's determination that the settling defendant did not adequately protect its interests will come with a price tag for additional attorneys' fees, post settlement.

From the plaintiff's perspective, the fundamental, longstanding obligation to honor Medicare's secondary payer status on conditional payments is unaffected by the recent changes to the law. What has changed is that the CMS will now have much more information it can use to collect reimbursement. It will receive notice of many more litigation settlements than it did previously. It seems likely that CMS will in many cases over claim reimbursement because its claim will be based on medical diagnostic codes. The diagnostic and procedure codes were not developed for this tracking purpose. A surgery on the left knee as a result of an accident and an unrelated surgery to the right look the same to Medicare, per the reporting codes. To be ready for a meaningful settlement conference or mediation, plaintiff's counsel will have to request conditional payment information from Medicare at least 60 days before the event, as Medicare is reserving for itself 8 weeks to provide such requested information. If the Medicare request for reimbursement is over-inclusive, it may take significantly longer to resolve that complication. If plaintiff's counsel has not worked through the process of receiving the numbers from Medicare, counsel will be unable to confer with the client and answer the all-important question: "So how much of this will I actually get?"

Statutorily, Medicare is entitled to recover all of a settlement up to the amount of conditional payments, less a nominal proportionate reduction to compensate plaintiff's counsel for the recovery from the primary payer. (The attorney's efforts are deemed "procurement costs.") If the settlement is less than the conditional payments, Medicare is entitled to reimbursement for the entire settlement, less a cut for plaintiff's counsel. The claimant could receive nothing. If the settlement exceeds the amount of the conditional

payments, Medicare is entitled to full reimbursement of its payments, less the deduction for plaintiff's attorney. The claimant gets the balance.[17] Medicare is not concerned with the liability aspects of a case; if an attorney settles a very thin liability case, Medicare is still entitled to reimbursement as above and is not obligated to add a liability factor discount to its claim for reimbursement in order to facilitate settlement. Once Medicare makes its demand, if the beneficiary has received a primary payment, the beneficiary or other party must reimburse Medicare within 60 days. 42 *C.F.R.* Section 411.24(h).

It is certainly possible that in cases involving many defendants and substantial medical expenses (an asbestos suit, for example) the plaintiff could settle with defendant after defendant after defendant and net nothing, further complicating the client control problems for plaintiff's attorney. Some clients may be satisfied to learn that each such settlement moves the plaintiff theoretically and incrementally closer to actually netting dollar one, but others may not.

As to the issue of future Medicare payments, it is a realistic possibility that a settled defendant could be called upon many years after a settlement to defend the allocation given to future medicals. With the typical retention cycle for attorney and claims files, such a defense might well be required where there is no claims file, no defense medical report, no attorney evaluations, and no documentation concerning the settlement negotiations that led to the eventual allocation in the agreement.

Given the present amorphous nature of the scheme for addressing future payments, and the fact that a verdict or judgment is presently the only allocation Medicare has indicated a willingness to accept as binding, there may well be increased requests for partial settlement. The defendant will be asked to try just the issue of future medicals. Plaintiffs will naturally push for a written settlement agreement that minimizes or trivializes the allocation to future medicals and the obligation to set aside settlement

---

[17] 42 CFR Sections 411.24 and 411.37

proceeds for Medicare reimbursement. While agreeing to such terms may make settlement easier, doing so increases the chances of Medicare attacking the allocation as unreasonable and collusive, exposing the settling defendant to the possibility of having to pay substantial portions of the settlement a second time.

If Medicare becomes sufficiently efficient to quickly match up the RRE's report with future medical bills, the CMS may take the position that it simply is not going to pay the health care providers for the services they thought they were providing to a Medicare beneficiary, further increasing the heavy burden that comes with accepting Medicare payments. There is no present mechanism for warning health care providers that a particular patient is uninsured for the treatment rendered.

10.

RECENT CASES OF INTEREST

There are at least two recent cases brought by the government that demonstrate Medicare is very serious about enforcing its rights under the MSP.

In *United States of America v. Harris*, USDC, ND of West Virginia, Civil Action No. 5:8CV102, 2009*U.S. Dist. Lexis* 23956, filed March 26, 2009, the court determined that the plaintiff beneficiary's attorney was liable under the MSP for the conditional overpayments made by Medicare for the beneficiary's pre-settlement medical treatment.

In *Harris*, the total liability settlement was for $25,000.00, and Medicare had made conditional payments of $22,549.67. However, based upon the amount and details of the settlement, Medicare had agreed to reduce its conditional payments and demanded a payment of only $10,253.59. That amount was not paid to Medicare within the required 60-day time period under the statute, and accordingly, the government filed its complaint against the beneficiary's attorney.

The defendant attorney filed a motion to dismiss and argued that a lawyer, in representing a client, cannot be individually liable under 42 *U.S.C.* section 1395y(b)(2)

when he or she distributes settlement funds to the clients. The district court disagreed with the argument, and on November 13, 2008, issued an order denying the defendant's motion to dismiss.

In its decision, the district court discussed the MSP extensively and Medicare's right to recover from any entity that had received a primary payment, including an attorney. Accordingly, attorneys should beware. Also, while the *Harris* case involved only recovery of conditional payments, it should be noted that the failure to adequately consider and protect Medicare's future interests may, likewise, result in liability for an attorney or an RRE, as illustrated in the next case.

In *United States v. Stricker, et al.*, USDC, ND of Alabama, Civil Action No. CV-09-PT-2423-E, filed in December of 2009, the United States on behalf of the CMS and the Secretary of Health and Human Services, initiated a lawsuit against the defendant corporations, their insurers, the plaintiffs, and the plaintiffs' counsel to obtain recovery for conditional payments made pursuant to the MSP. While prior lawsuits such as *Harris* discussed above, have generally sought reimbursement from plaintiffs or plaintiffs' counsel for failure to repay Medicare, the *Stricker* case is slightly different in that it is the first case which seeks reimbursement, in a single action, from all parties subject to MSP reimbursement obligation, including the insureds, their liability insurers and the plaintiffs' counsel.

In *Stricker*, the plaintiffs had settled their liability case against the defendant corporations in 2003 for approximately $300 million. The complaint filed by the government alleges that none of the 907 Medicare beneficiary plaintiffs reimbursed Medicare as they were legally obligated to do. Likewise, neither the plaintiffs' attorneys, the defendant corporations, nor their insurers investigated Medicare's potential claims, notified Medicare of the settlement, or reimbursed Medicare for its conditional payments made to the beneficiaries. Consequently, just before the statute of limitations expired, the

government initiated suit against all parties for double the amount of the outstanding liens.

Of note, in *Stricker*, in addition to seeking conditional payments, interest and penalties, the government is requesting that "the defendants must give CMS notice of all future payments to Medicare beneficiaries pursuant to 42 *C.F.R.* section 411.25; and, that all defendants must ensure before any future settlement payment is made to any claimant that appropriate payment is made to the United States." Clearly, the government claim in *Stricker* seeks to establish a right to proceed against the liability insurers for both pre and post-settlement Medicare expenses. This is a dramatic move from the traditional approach to post-settlement exposure of liability insurers and could be an omen of future government actions. The final decision in the *Stricker* case may have far reaching effects on liability insurers and their settlements with Medicare beneficiaries.

11.

STATUTORY RESOURCES

The MSP mandatory reporting provisions created by Section 111 of the MMSEA in 2007 are codified in 42 *U.S.C.* section 1395y(b)(7) and (b)(8). See Appendix F – "MMSEA Section 111 Statutory Language," CMS User Guide, Version 3, February 22, 2010; pp. 240-242.

The implementation scheme for Medicare's recovery of conditional payments is contained in the *Code of Federal Regulations* at 42 *C.F.R.* section 411.20 *et seq.* For example, section 411.21 defines key terms such as "conditional payment" and "primary payer," among others. The reimbursement obligations of primary payers and beneficiaries are set forth in section 411.22. A beneficiary must cooperate in CMS's actions to recover conditional payments. 42 *C.F.R.* section 411.23. The rules for recovery of conditional payments are contained in section 411.24. This section provides, among other things, that Medicare may proceed against primary payers and may recover up to double the amount if it has to file a suit to collect. Finally, section 411.37 describes

the amount of a Medicare recovery when a primary payment is made as a result of a judgment or settlement and CMS sues the party (beneficiary) receiving payment.

12.

CONCLUSION

As the foregoing discussion demonstrates, implementation of the new rules relating to the MSP has made settling cases with Medicare beneficiaries a more challenging and difficult process. Settlements will take longer and require the earnest cooperation of all parties to avoid running afoul of Medicare's enforcement provisions. The attorneys for both sides will have to engage in more leg work and information gathering to prepare for settlement. Without clear guidance from the CMS, the parties and their attorneys will have to do their best to account for consideration of Medicare's interests in any settlement agreement.

However, with all of this being said, there is hope on the horizon for some clarification of the parties' responsibilities in satisfying Medicare's interests. As this article was being completed, the authors received word that a bill, H.R. 4796,[18] has been introduced in the House of Representatives. The announced purpose of H.R. 4796 is to amend Title XVIII of the Social Security Act with respect to the application of Medicare secondary payer rules for certain claims. Based on a quick review, the bill, among other things, provides for: a calculation process for repayment of past conditional payments; establishing thresholds for reporting claims; establishing reporting requirement safe harbors; limiting the obligation of RREs to report beneficiary SSNs or HICNs; and establishing a three-year statute of limitations on any enforcement action brought by the government. Clearly, if the proposed bill is adopted, the prospect for successful settlements with a high degree of certainty will be considerably improved.

---

[18] A copy of H.R. 4796 is attached as Exhibit "A".

EXHIBIT "A"

.....

(Original Signature of Member)

111TH CONGRESS
2D SESSION

H. R. _____

To amend title XVIII of the Social Security Act with respect to the application of Medicare secondary payer rules for certain claims.

IN THE HOUSE OF REPRESENTATIVES

Mr. PATRICK MURPHY of Pennsylvania (for himself and Mr. TIM MURPHY of Pennsylvania) introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act with respect to the application of Medicare secondary payer rules for certain claims.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Secondary Payer Enhancement Act of 2010".

SEC. 2. CALCULATION AND DIRECT PAYMENT OF MSP CLAIMS.

(a) CALCULATION AND DIRECT REIMBURSEMENT OF CONDITIONAL PAYMENT FOR SETTLEMENT PURPOSES.—

(1) Section 1862(b)(2)(B) of the Social Security Act (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

"(vii)(I) VOLUNTARY CALCULATION AND PAYMENT OF CONDITIONAL PAYMENT.—In the case of a settlement, judgment, award, or other payment between a claimant and an applicable plan (as defined in paragraph (8)(F)) involving a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, for purposes of determining the amount of reimbursement required under clause (ii) to the appropriate Trust Fund during the 90-day period preceding the reasonably expected date of such settlement, judgment, award, or other payment, the claimant and plan may—

"(aa) in good faith calculate the amount of such reimbursement required based upon available billing

data for such items and services provided; and

"(bb) reimburse such amount to the appropriate Trust Fund, in accordance with regulations promulgated by the Secretary.

With respect to a payment made under clause (i) for items and services provided to a claimant and subject to subclause (II), any reimbursement made in accordance with this subclause shall satisfy any obligation of the claimant and the applicable plan under this subsection.

"(II) SECRETARY'S ABILITY TO CONTEST AMOUNT OF PAYMENT.—In the case of a reimbursement made to the appropriate Trust Fund under subclause (I), during the 75-day period beginning on the date of such reimbursement, if the Secretary determines such reimbursement made is not the total amount owed under this subparagraph the Secretary shall have the right to contest the amount of such reimbursement made and to serve upon the

claimant and applicable plan a final demand for the balance of the remaining amount so owed. The claimant or applicable plan may make a reimbursement to the appropriate Trust Fund in the amount of such balance determined by the Secretary or may pursue appeal of the amount of the reimbursement determined by the Secretary pursuant to the appeals process under clause (ix). In any such appeal, the burden of proof shall be on the claimant or applicable plan to demonstrate that the reimbursement made to the appropriate Trust fund under subclause (I) was correct.

"(viii)(I) REQUEST FOR FINAL DEMAND FOR REIMBURSEMENT.—In the case of a settlement, judgment, award, or other payment between a claimant and an applicable plan (as defined in paragraph (8)(F)) involving a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan may at any time beginning 120 days prior to the rea-

sonably expected date of such settlement, judgment, award, or other payment, submit to the Secretary, in accordance with regulations to be promulgated by the Secretary, a request for a recovery demand letter for reimbursement required under clause (ii) of such payment. The Secretary shall have 60 days to respond to such request with such final demand. Not later than 60 days after the date of receipt of such final demand, the claimant or applicable plan may reimburse the appropriate Trust Fund for such payment in the amount identified in such final demand, in accordance with regulations promulgated by the Secretary. With respect to a payment made under clause (i) for items and services provided to a claimant, any such reimbursement made in accordance with this subclause shall satisfy any obligations of the claimant and the applicable plan under this subsection.

"(II) FAILURE OF THE SECRETARY TO PROVIDE FINAL DEMAND FOR CONDITIONAL PAYMENT.—In the case that the

Secretary fails to provide a final demand for any item or service subject to reimbursement required under clause (ii) in accordance with subclause (I), the claimant, applicable plan, or an entity that receives payment from an applicable plan shall not be liable for and shall not be obligated to make payment subject to this subsection for any item or service related to the request for final demand for reimbursement.

"(ix) RIGHT OF APPEAL.—The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any requirement under clause (ii) for a payment made under this title for an item or service under a primary plan, under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such applicable plan may appeal such requirement. Such right of review shall—

"(I) include review through an administrative law judge and administrative review board, and access to judicial review in the district court of the United States for the judicial district in which the appellant

is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia; and

"(II) be carried out in a manner similar to the appeals procedure used for purposes of subsection (a).".

(2) CONFORMING AMENDMENT.—Clause (ii) of such section is amended by inserting after "60-day" the following "(or in the case of an applicable plan and reimbursement described in clause (vii) or (viii), 90-day)".

SEC. 3. THRESHOLD.

(a) IN GENERAL.—Section 1862(b)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking "(ii) REPAYMENT REQUIRED.—A primary plan" and inserting the following:

"(ii) REPAYMENT REQUIRED.—

"(I) IN GENERAL.—A primary plan"; and

(2) by adding at the end the following new subclause: "

"(II) EXCEPTION.—Subclause (I) shall not apply with respect to the following payments under this title:

"(aa) Any settlement, judgment, award, or other payment by an applicable plan constituting a total payment obligation to a claimant of not more than $5,000.

"(bb) Any settlement, judgment, award, or other payment by an applicable plan involving the ongoing responsibility for medical payments not otherwise addressed in subclause (I), of not more than $5,000. For purposes of this subclause and with respect to a settlement, judgment, award, or other payment payments not otherwise addressed in subclause (I) involving the ongoing responsibility for medical payments, such payment shall include only the cumulative value of the medical payments made

and the purchase price of any annuity or similar instrument.

The amounts under this subclause shall be adjusted each year based on the percentage increase in the Consumer Price Index (rounded to the nearest multiple of $100) for the year involved.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to payments made on or after 3 months after the date of the enactment of this Act.

SEC. 4. REPORTING REQUIREMENT SAFE HARBORS.

Section 1862(b)(8) of the Social Security Act (42 U.S.C.1395y(b)(8)) is amended—

(1) in the first sentence of subparagraph (E)(i), by striking "shall be subject" and all that follows through the end of the sentence and inserting the following: "may be subject to a civil money penalty of up to $1,000 for each day of noncompliance. The severity of each such penalty shall be based on the intentional nature of the violation."; and

(2) by adding at the end the following new subparagraph:

"(I) SAFE HARBORS.—Not later than 60 days after the date of the enactment of this subparagraph, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60–day period, for the creation of safe harbors from sanctions imposed under subparagraph (E) under which entities responsible for reporting information under this paragraph will be deemed to have complied with the reporting requirements under this paragraph and will not be subject to such sanctions. After considering the proposals submitted pursuant to the preceding sentence, the Secretary, in consultation with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed safe harbors. After considering any public comments received during such period, the Secretary shall issue final rules establishing safe harbors from penalties or other sanctions under subparagraph (E).".

SEC. 5. USE OF SOCIAL SECURITY NUMBERS AND OTHER IDENTIFYING INFORMATION IN REPORTING.

Section 1862(b)(8)(B) of the Social Security Act (42 U.S.C. 1395y(b)(8)(B)) is amended by adding at the end

(after and below clause (ii)) the following sentence: "Not later than one year after the date of enactment of the Medicare Secondary Payer Enhancement Act of 2010, the Secretary shall modify the reporting requirements under this paragraph so that entities responsible for reporting information under this paragraph are not required to access or report to the Secretary beneficiary social security numbers or health identification claim numbers.".

SEC. 6. STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Section 1862(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(B)(iii)) is amended by adding at the end the following sentence: "Every action brought by the United States or an officer or agency thereof under this clause shall be barred unless the complaint is filed not later than three years after the date of the receipt of notice of a settlement or other payment giving rise to recovery of a payment made pursuant to paragraph (8).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to actions brought on or after 6 months after the date of the enactment of this Act.

SEC. 7. USER FEE.

Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding the following new paragraph:

"(9) USER FEES.—

"(A) IN GENERAL.—Beginning 90 days after the date of the enactment of the Medicare Secondary Payer Enhancement Act of 2010, and annually thereafter for the 10-year period beginning on such date of enactment, the Secretary shall assess and collect fees in accordance with this paragraph as follows:

"(i) DIRECT CONDITIONAL PAYMENT REIMBURSEMENT FEE.—Each person or entity that submits a payment to fulfill the reimbursement requirement pursuant to paragraph (2)(B)(vii) shall be subject to a fee of $30 for each payment reimbursed to the Secretary.

"(ii) REQUEST FOR FINAL DEMAND OF CONDITIONAL PAYMENT FEE.—Each person that submits a request for a recover demand letter of conditional payment under paragraph (2)(B)(viii) shall be subject to a fee of $30 for each such request submitted to the Secretary. In the case of

a person or entity that pays a fee under this clause, such person or entity shall not also be subject to the fee under clause (i).

"(B) INFLATION ADJUSTMENT.—For fiscal year 2010 and subsequent fiscal years, the amount of the fees specified in subparagraph (A) shall be adjusted by the Secretary by notice, published in the Federal Register, to reflect any percent changes in the Consumer Price Index for all urban consumers (all items; U.S. city average) for the 12 month period ending June 30 of the preceding fiscal year.

"(C) COLLECTION OF UNPAID FEES.—In any case where the Secretary does not receive payment of a fee assessed under subparagraph (A) by the date that is 30 days after the date such fee is due, such fee shall be treated as a claim of the United States Government subject to subchapter II of chapter 37 of title 31, United States Code.".