Secondary Payor Requirements May Impact Settlements

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By Sheryl Willert

In the waning days of 2007, with the cost of health care continually escalating and with more and more of the costs being borne by the United States Government, Congress passed and President Bush signed into law the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). With the stroke of his pen, the President created a responsibility for self insured organizations, liability insurers, group health plans and non-group health plans that pay bodily injury claims to insure that the Medicare system is protected from bearing the costs of current and future medical expenses if those expenses are the primary responsibility of an entity other than Medicare. Entities making such payments are known as RREs. In order to fulfill their responsibility, for each recipient of payments, RREs are required to make a determination as to whether the individual is a Medicare recipient and report any and all payments to the Center for Medicare and Medicaid Services (the CMS) for a determination of the subrogation rights as of that date. In order to ensure that there is an accurate determination of the subrogation rights, it will be imperative that all RREs obtain a social security number of the payment recipient and use that social security number in its reporting.

The law specifically requires that RREs register with Medicare's Coordination Benefit Contractor (COBC) so that a mechanism for forwarding appropriate information and data can be established. This registration process was to have occurred between May 1, 2009 and June 30, 2009.

The next milestone in the process of implementing the statute occurred between July 1, 2009 and September 30, 2009 when initial rounds of data were accepted by the CMS. Between October 1, 2009 and December 31, 2009 and for every quarter thereafter, all RREs must submit quarterly reports about affected Medicare beneficiaries who were eligible as of July 1, 2009 or any date thereafter. All RREs were required to be in compliance with this statute not later than January 1, 2010. RREs can use agents to fulfill these functions. Failure to be in compliance will result in a $1,000 per claim per day fine. It has been estimated by the Congressional Budget Office that the failure of RREs to comply with this law will result in the generation of $1.1 billion in fines over the first five years of its existence.

In addition to monetary fines, another significant impact of this statute will be a necessary change in the manner in which personal injury claims are evaluated for settlement, regardless of whether litigation is commenced. The net effect of the statute is likely to be that the minimum settlement value of claims increases to the projected Medicare subrogation amount.

And if you don't think this is serious, litigation is already budding from this statute. On March 26, 2009, in the matter of *United States of America v. Paul J. Harris*, United States District Court, Northern District of West Virginia, Civil Action No. 5:08CV102, a federal judge entered an order against an attorney who settled a claim and failed to insure that the CMS received $10,253.59 for reimbursement of conditional payments. The attorney did not prevail.

The government was able to prevail because the court found that there was no ambiguity with respect to the actions which must be taken with respect to Medicare payments. The court noted that 42 U. S. C. § 1395y (b)(2)(B) and 42 C.F. R § 411.24.g provide that any entity that receives payments from a primary plan is responsible to reimburse the appropriate Trust Fund for any payments made by that Fund; that the government could bring an action against any and all entities responsible to insure reimbursements and that any entity responsible for reimbursements included beneficiaries, suppliers, physicians, attorneys and insurers.

On a related issue, the United States government recently filed a lawsuit against a number of attorneys and insurers for failure to comply with the provisions of 42 U. S. C. § 1395y (b)(2)(iii) which required that parties to litigation notify the government where payments were made to Medicare recipients in order to protect the interests of Medicare. In USA v. Stricker, et. al., (CV-09-PT-2423E (Northern District of Alabama, 12/09) the government seeks double damages and has eschewed the argument by insurers and others that the proceeds of settlement have already been paid out.

Why do either of these issues matter to employers or employment lawyers, mainly because they must be concerned about the issue of Medicare payments in settlement negotiations if any employee has instituted litigation or made claims for personal injury against the employer.

Both of these matters point up the importance of inquiring about Medicare payments and negotiating reimbursement of any Medicare payments. Additionally, these cases point up the importance of notifying the government of settlements with any employee or former employee who receives Medicare payments.