porterwright

Litigation Law Alert

A Product Liability Practice Group Publication

September 2009

Terrance M. Miller
614-227-2142
tmiller@porterwright.com

Joyce D. Edelman
614-227-2083
jedelman@porterwright.com

Daniel B. Miller
614-227-2101
dbmiller@porterwright.com

Elizabeth L. Moyo
614-227-2106
emoyo@porterwright.com

Please see our other publications at www.porterwright.com/publications.

Are You in Compliance with the Mandatory Reporting Requirements Under the Medicare, Medicaid and SCHIP Extension Act of 2007?

The Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA") took effect July 1, 2009. One of the purposes of MMSEA is to allow the federal government to recover payments made under Medicare when Medicare incorrectly acted as a primary payer or when a Medicare beneficiary receives payments from both an insurer and Medicare for the same injury. To that end, MMSEA requires group health plan arrangements ("GHPs") and liability insurers, no-fault insurers, workers' compensation insurers, and self-insurers (collectively, "non-GHPs") to report any settlement, award, judgment, or other payment that they make involving a Medicare beneficiary to the Centers for Medicare and Medicaid Services ("CMS"), the federal agency within the U.S. Department of Health and Human Services that is responsible for administering Medicare.

Who Must Register?

MMSEA applies not only to GHPs, such as employers with group health plan arrangements, and non-GHPs, such as automobile insurance companies, but also self-insured businesses. In other words, any business that carries its own risk (whether by a failure to obtain insurance or otherwise) in whole or in part must register with CMS. If you have not registered already, the deadline for registration and testing for non-GHPs is September 30, 2009. The CMS registration website is https://www.section111.cms.hhs.gov/MRA/LoginWarning.action.

What Must Be Reported?

The duty to report is triggered any time a GHP or non-GHP (collectively referred to as responsible reporting entities or "RREs") expects to make a payment to a Medicare beneficiary. An RRE must report to CMS all payments to Medicare beneficiaries and any expected payments to Medicare beneficiaries, including payments arising from personal injury claims, regardless of whether that payment or expected payment is made pursuant to a settlement, judgment, or other resolution of the claim.

Each RRE must determine whether an injured claimant is a Medicare beneficiary or is entitled to Medicare coverage. If the claimant is entitled to or already receives Medicare coverage, the RRE must report certain information about the claimant, including the claimant's identity. RREs are required to

submit quarterly reports to CMS during a seven-day timeframe designated by CMS.

Since July 1, 2009, GHPs have been required to submit quarterly reports. For non-GHPs, quarterly reports will be required beginning in early 2010; however, the first report submitted must be retroactive to include all payments on or after July 1, 2009.

Are There Other Requirements?

MMSEA requires all parties to "consider Medicare's interests." In particular, the act imposes additional requirements for payments made to a Medicare beneficiary as a result of the resolution of a workers' compensation claim. CMS requires that the resolution of such claims include the establishment of a Medicare Set Aside Account ("MSA") to pay for future medical expenses that would otherwise be paid by Medicare. In certain circumstances, the MSA must be approved by CMS.

Although CMS does not presently obligate liability and other non-workers' compensation insurers to create an MSA if the settlement does not involve a workers' compensation claim, CMS recommends that an MSA be included in all settlement agreements involving Medicare beneficiaries.

What If You Fail To Report?

Beginning July 1, 2009, insurers face a penalty of up to $1,000 per day for each Medicare claimant whose Medicare status is not fully reported to CMS. Medicare beneficiaries who receive a liability settlement, judgment, award, or other payment have an obligation to pay back any conditional payments paid by Medicare within 60 days of receiving the funds. If Medicare is not reimbursed, or if an insurer fails to provide primary payment as it is required, Medicare may bring a cause-of-action against any entity — including Medicare beneficiaries, their counsel, and insurers — that received funds that should have paid injury-related medical expenses rather than Medicare.

What Should You Do To Ensure Compliance With The MMSEA?

Although we have yet to see how MMSEA will be enforced, the consequences of noncompliance are severe. The act has broad implications and could arguably apply to nearly all tort cases involving permanent injuries, regardless of the age of the plaintiff. Accordingly, you should always consult with your attorney to determine whether the reporting requirements are triggered by your particular matter.

In addition, businesses should consider the following practices:

- Become familiar with the reporting system, and establish a process for reporting;
- When a claim involving medical expenses is made, develop an investigation process and discovery materials to determine the claimant's eligibility under Medicare;
- Identify the information that must be reported to CMS;
- Include an indemnity provision in any settlement agreement to protect against any action brought by Medicare to recover funds;
- Identify Medicare's interests, if any, in your settlement agreement;
- Draft separate settlement checks for the claimant and CMS; and/or
- Create a Medicare Set Aside Account as appropriate.

These recommendations are not exclusive, should be discussed with an attorney, and may not be appropriate in every instance.