INSURERS REQUIRED TO REPORT SETTLEMENTS TO MEDICARE STARTING JULY 1, 2009

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(*This article originally appeared in the Spring 2009 edition of the Jones, Skelton & Hochuli Reporter publication)*

Beginning July 1, 2009, every insurer (including no-fault and self-insured policies) will be required to report first and third party personal injury settlements and workers' compensation settlements to Medicare whenever Medicare paid medical expenses on behalf of its beneficiary that are part of the settlement proceeds. This change is part of an Amendment to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, signed into law by former President Bush. *See* 42 U.S.C. §1395y(b)(7) & (8). This Amendment marks a significant change in the way Medicare liens are handled by effectively shifting the burden to the insurer to put Medicare on notice of settlements so that they can pursue their statutory right of reimbursement.

A Medicare right of reimbursement, sometimes referred to as a "superlien" because of its supremacy over all other liens and/or rights of reimbursement,[1] is governed by the Medicare Secondary Payer statute, set forth in Section 1862(b) of the Social Security Act.[2] Section 1862(b)(2)(B)(ii) provides that when a Medicare beneficiary is injured as the result of the negligence of another, the medical expenses should be paid by the "primary plan" or the liability insurance policy; Medicare is considered a "secondary plan." However, to facilitate the

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[1] *See U.S. v. Geier*, 816 F.Supp. 1332, 1334 (W.D.Wis. 1993).

[2] Section 1862 [42 USC 1395y] (2) Medicare secondary payer.—

> (A) In general.—Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—
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> (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.
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> In the subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

coordination of treatment and benefits, Medicare often pays the medical expenses up front as a "conditional payment" and then seeks recovery from the "primary plan."[3] This is, in essence, how the Medicare "lien" or right of reimbursement is created. Pursuant to 28 USC §2415(a), Medicare has six years to pursue its subrogation rights.

Currently, the personal injury claimant/plaintiff's attorney takes responsibility for contacting Medicare to determine if it will be seeking reimbursement, and if so, to request a conditional payment letter. Then, after the settlement is finalized, the claimant's attorney negotiates and compromises the lien. If the Medicare lien is not compromised or paid, Medicare can pursue a direct right of action against its beneficiary, her attorney, and the insurer and its attorney.[4] Beginning July 1, 2009, in order to assist Medicare in identifying and pursuing its lien rights, the insurer must report its personal injury settlements *directly* to Medicare. Failure to do so may result in $1,000 per day fines and double damages. *See* 42 USC §1395y(b)(7) and (8).

In light of the Amendment to the statute, how do insurers report settlements? Based upon information from the CMS website (www.cms.hhs.gov), the intent is to have all insurers report electronically. When a claim is presented that involves Medicare payments, the insurer should open an MSP (Medicare Secondary Payor) claim with the COBC (Coordination of Benefits Contractor). CMS (Centers for Medicare & Medicaid Services) is responsible for the oversight of Medicare and has been charged with implementing the new reporting requirements. CMS is going to begin the registration of insurers, or RREs (Responsible Reporting Entities), in May, 2009, through the internet. More information about the registration process can be found at www.cms.hhs.gov/MandatoryInsRep. Once an insurer is registered as an RRE, it can then report electronically. An attorney representing a Medicare beneficiary can also open a claim with the COBC by phone or in writing.

Attorneys handling personal injury and workers' compensation cases will need to do the following in order to assist their insurance carrier clients in complying with the reporting requirements:

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[3] Section 1862 [42 USC 1395y] (2)(B) Conditional payment.—

(i) Authority to make conditional payment.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

[4] Section 1862 [42 USC 1395y] (2)(B) Conditional payment.—

(iii) Action by united states.—In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity.

1. Identify as early on in the litigation as possible whether the case involves Medicare. This can be done through a letter to opposing counsel or in the form of a non-uniform interrogatory.

2. Obtain the Medicare beneficiary's Social Security Number and his or her Health Insurance Claim Number (HICN). This information must be included in the reporting process.

3. Modify your Settlement Releases, and if applicable, your settlement check transmittal letters to reflect that the case involves Medicare and that the claimant/plaintiff acknowledges that pursuant to 42 USC §1395y(b)(7) & (8), the settlement will be reported to Medicare.

4. Obtain confirmation of the Medicare reporting from the insurer and include it as part of your documentary file prior to closing.

Finally, it is important to keep in mind that the new reporting requirements will not affect a beneficiary's ability to dispute Medicare's claim for reimbursement and/or set aside. A beneficiary will still be able to pursue an administrative appeal (42 USC §1395ff), compromise (42 C.F.R. §405.376), or waiver (42 USC §1395gg).