THE MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007:

A PRACTITIONER’S INTRODUCTION TO RESOLUTION OF PERSONAL INJURY LIABILITY CLAIMS INVOLVING MEDICARE BENEFICIARIES

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I. INTRODUCTION

With ever-rising health care costs, expansion of government powers to recoup government-provided expenditures should come as no surprise. Effective on July 1, 2009, the Medicare, Medicaid and SCHIP Extension Act of 2007 (“MMSEA”) represents a substantial enlargement of the federal government’s ability to seek reimbursement for past and future Medicare payments. By imposing stringent reporting requirements and stiff penalties on Group Health Plans (“GHPs”) and non-Group Health Plans (“non-GHPs”) (i.e., liability insurance - including self-insurance, no-fault insurance, and workers’ compensation insurance) involved in an estimated 2.7 million personal injury liability claims, the MMSEA provides Medicare additional tools with which to seek reimbursement for Medicare claims. In essence, the MMSEA will require practitioners handling personal injury liability claims brought by Medicare beneficiaries to give serious, ongoing, and proactive consideration to past and future medical expenses covered by Medicare.

For those practitioners heretofore unfamiliar with the Medicare Secondary Payer Act, this article attempts to provide an introduction to the Secondary Payer Act and the MMSEA, focusing exclusively on Medicare reimbursement obligations for non-GHPs. In particular, the article will attempt to explain the MMSEA’s implications in the context of personal injury liability claims and what practitioners can do to not only ensure statutory compliance, but also to reduce the risk of increased exposure in such cases. Because the MMSEA is grafted onto existing legislation (the Secondary Payer Act), this article first addresses the Secondary Payer Act and its obligations and potential penalties. In light of the expanded reach of Medicare into the realm of personal injury litigation through the MMSEA and the attendant risks of failing to comply, the importance
of familiarization with these statutes cannot be overstated.

II. AN OVERVIEW OF MEDICARE AND THE SECONDARY PAYER ACT

A. Introduction To Medicare

Medicare is the federal health insurance program for individuals over the age of sixty-five and individuals under age sixty-five with permanent disabilities and permanent kidney failure. Part of the Department of Health and Human Services, the Centers for Medicare & Medicaid Services (“CMS”) is the government agency responsible for oversight of the Medicare program, including implementation of the MMSEA.

B. The Medicare Secondary Payer Act

The Medicare Secondary Payer Act (“MSPA”) applies to situations where another entity is required to pay for covered services before Medicare does, and it must do so without regard to a patient’s Medicare entitlement. When Medicare was first established, it was the “secondary” payer for medical services covered by workers’ compensation, and the “primary” payer for all other medical services provided to eligible participants.

In direct response to increasing financial burdens on Medicare and to shift costs from the Medicare program to private payment sources, Congress in the 1980's enacted the first series of provisions that made Medicare the secondary payer when additional insurance was available to assume primary responsibility for medical payments, and as a result, Medicare is no longer the primary payer for medical services. As discussed below, the MMSEA represents the most recent expansion of the Secondary Payer Act.

In general, Medicare is “secondary” in two situations. First, Medicare is a secondary payer to GHPs for medicare beneficiaries who (1) are sixty-five and older and who have GHP

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coverage on the basis of their own or their spouse’s current employment with an employer that has least twenty employees; (2) are younger than sixty-five and disabled and who have GHP coverage on the basis of their own or their spouse’s current employment with an employer that has least 100 employees; or, (3) have End Stage Renal Disease and who have GHP coverage on any basis. Second, Medicare is a secondary payer when certain types of non-GHP insurance coverage, including liability (including self-insurance), no-fault, and workers’ compensation insurance are responsible for a Medicare-eligible individual’s health care expenses.

C. Reimbursement Of Medicare “Conditional” Payments

1. Medicare Conditional Payments Defined

Medicare’s past payments are considered “conditional,” and as a secondary payer, Medicare can and will seek reimbursement from GHPs and non-GHPs (“primary payers”) for conditional payments if it determines that those payments were the responsibility of a primary payer. Thus, as a secondary payer, Medicare conditionally pays for treatment with the expectation of reimbursement for those payments.

Conditional payments can also arise when (1) a claim is denied or disputed by the primary payer; (2) the primary payer fails to make prompt payment; (3) Medicare makes payment without knowledge of the primary payer’s existence; (4) the claimant fails to document the primary payer’s existence; (5) Medicare is mistakenly billed instead of the primary payer; and, (6) the beneficiary fails to file a proper claim due to mental or physical incapacity.

2. Timing Of Reimbursement To Medicare

A Medicare beneficiary who receives payments from a primary payer must reimburse Medicare within sixty (60) days of receiving payment. To that end, CMS’s right to seek
recovery accrues when a primary payer pays for a Medicare conditional payment by settlement, judgment, or “other means.” CMS cannot demand reimbursement until the beneficiary’s claim is settled.

3. Amount Owed To Medicare

Medicare has a right to reimbursement for health care services that a primary plan has or had a “responsibility” to pay. Because CMS’ right to recover conditional payments does not accrue until after a settlement has been reached, a conditional payment can be difficult to compromise and to reduce below its actual amount. Moreover, Medicare is entitled to reimbursement regardless of whether or not there has been a finding or admission of liability.

Nevertheless, the beneficiary can somewhat reduce the reimbursement amount owed by any “procurement costs”—the costs the beneficiary paid to an attorney in pursuing her claim. Moreover, the Medicare Secondary Payer Manual suggests that with CMS’ early involvement prior to settlement, the parties may be able to compromise the amount owed to Medicare.

D. Protecting Medicare’s Interests In Future Medical Expenses

In the context of workers’ compensation claims, CMS has developed and issued guidelines on how claimants are to consider and protect Medicare’s financial interests regarding future medical expense payments. By contrast and as discussed below, CMS has yet to provide any clear guidance on how to consider Medicare’s interests in personal injury liability claims.

1. Medicare Set Aside Arrangements

For workers’ compensation claims, a Medicare Set Aside ("MSA") is a CMS-recommended method of protecting Medicare’s future financial interests by carving out a portion of any settlement proceeds for future medical expenses. A set aside arrangement should be
utilized and submitted for CMS review under either of the following two scenarios:

1. The claimant is currently a Medicare beneficiary and the total settlement amount is greater than $25,000; or,

2. The claimant has a “reasonable expectation” of Medicare enrollment within thirty (30) months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.21

A claimant has a “reasonable expectation” of Medicare enrollment when the individual (1) has applied for Social Security Disability Benefits; (2) has been denied Social Security Disability Benefits but anticipates appealing that decision; (3) is in the process of appealing and/or re-filing for Social Security Disability Benefits; (4) is 62 and six months old; or, (5) has an End Stage Renal Disease condition but does not yet qualify for Medicare.22

Not all circumstances require a set aside arrangement. For example, CMS currently does not require initiation or approval of set aside arrangements for liability-based claims. Additionally, if future medical expenses of a workers’ compensation claim remain “open,” then a set aside arrangement is unnecessary because the primary payer (i.e., the workers’ compensation insurer) continues to cover the ongoing medical expenses and Medicare remains a secondary payer.23 Finally, CMS has stated that an MSA is not necessary if all of the following apply:

1. The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e, for services furnished prior to settlement);

2. There is no evidence that the individual is attempting to maximize the other aspects of the settlement (i.e., lost wages and disability) to Medicare’s detriment; and,

3. The individual’s treating physicians concluded in writing that to a reasonable degree of medical certainty, the individual will no longer
require any Medicare-covered treatments related to the workers’ compensation injury.  

2. **How Much To Allocate In A Medicare Set Aside**

   Generally, the primary payer has responsibility for only those expenses that Medicare would have that are related to the claimant’s injury. Thus, the settlement should allocate an amount approximating the expected future medical expenses that would otherwise be covered by Medicare over the claimant’s life expectancy.

   While difficult to determine, the computation of this amount should include, but is not limited to, all future medical expenses (including prescription drugs), repayment of any Medicare conditional payments, previously settled portions of a workers’ compensation claim, life expectancy, inflation, administrative fees, wages, and attorney fees. Careful consideration should be given to inclusion of the set-aside calculation formula in related settlement documents.

3. **Exhaustion Of Set Aside Funds And Subsequent Medicare Benefits**

   Once the CMS-approved set aside amount has been exhausted and accurately accounted for to CMS, Medicare will then agree to pay “primary” for future Medicare-covered expenses related to the workers’ compensation injury.

4. **Administration Of A Set Aside Arrangement**

   The Medicare beneficiary may “self-administer” the set-aside arrangement, if permissible under state law. A set aside arrangement may also be professionally administered. In either case, these funds must only be spent for future injury-related treatment.

E. **Enforcement Of Medicare’s Right To Reimbursement**

   Practitioners should be particularly familiar with the potential significant exposure that
the Secondary Payer Act (and as set forth below, the MMSEA) creates for them and their clients. Because a large part of the Secondary Payer Act’s purpose was to shift costs from the Medicare program to private sources, the Secondary Payer Act and MMSEA contain significant tools available for CMS to implement those cost-shifting goals.

First, the Secondary Payer Act gives Medicare automatic subrogation rights for its conditional payments. Therefore, if Medicare makes secondary payments for medical services, Medicare is entitled to reimbursement from the primary payer and from the entity or individual that receives payment from the primary plan, when the primary plan pays the claim.

Second, to enforce its subrogation rights, CMS has the right to initiate recovery efforts for conditional payments as soon as it learns that payment has been made or could be made by any of the plans responsible for primary payment. To that end, CMS can bring an action against “any or all entities that are or were required or responsible” for primary payments and that fail to reimburse Medicare for them. Notably, one federal district court recently held that a plaintiff’s attorney was liable for reimbursing Medicare’s conditional payments.

Third, Medicare’s potential remedies are severe. If CMS is forced to bring suit against a primary payer, Medicare is entitled to recover double damages plus interest. If CMS takes no legal action to recover its conditional payments, CMS may recover the lesser of the conditional payment or the full payment that the primary payer is obligated to pay. Even if Medicare is not timely reimbursed, the non-GHP is still required to reimburse Medicare two times the reimbursement amount, even if a primary payer has already paid the Medicare beneficiary. Finally, CMS has the right to reject any settlement and to refuse payment of future benefits.

Fourth, the Secondary Payer Act provides for a private cause of action. Like Medicare’s
right to initiate suit, a Medicare beneficiary can sue a primary payer that fails to reimburse Medicare or otherwise make primary payment.  Moreover, a private litigant’s claim against a primary payer “shall be in an amount double the amount otherwise provided.”

III. THE MMSEA AND ITS EXPANSION OF THE SECONDARY PAYER ACT’S REACH INTO PERSONAL INJURY LIABILITY CLAIMS

A. Overview Of The MMSEA

Effective on July 1, 2009, the MMSEA significantly expands the reach of the Secondary Payer Act, injecting it fully into the realm of personal injury liability claims by imposing upon non-GHPs strict reporting requirements and potentially stiff penalties for non-compliance. Under the MMSEA, Responsible Reporting Entities (“RREs”) are required to report to CMS specified information regarding GHP arrangements and non-GHP arrangements to ensure proper coordination of benefits with the Medicare program.

In general, the MMSEA requires an RRE to determine whether a “claimant” who has brought a claim against an RRE or an entity insured by an RRE is eligible for Medicare benefits. Should a claimant be Medicare-eligible, the RRE must report specific information to CMS until the claim is resolved by settlement, judgement, or other payment. Failure to comply with the MMSEA and existing provisions of the Secondary Payer Act can result in liability to not only claimants and defendants alike, but also to insurers, their insureds and their attorneys.

On its face, the MMSEA imposes upon non-GHPs reporting requirements and attendant fines for failure to report. However, in its application, the MMSEA mandates that non-GHPs, claimants, defendants, and their counsel “reasonably consider” Medicare’s interests in handling personal injury liability claims involving Medicare beneficiaries or face staggering penalties.
B. Responsible Reporting Entities Defined

In general, a non-GHP Responsible Reporting Entity is an employee or defendant’s insurance carrier (i.e., workers’ compensation insurer, general liability insurer, or no-fault insurer).\textsuperscript{47} If an employer or defendant is self-insured for workers’ compensation or liability insurance, the employer may be an RRE.\textsuperscript{48} If an employer or defendant is self-insured for any deductible, the insurer constitutes the RRE.\textsuperscript{49}

C. How Reporting Entities Determine Medicare Eligibility

An RRE can determine Medicare status in a variety of ways. First, an RRE can request that the claimant provide his or her Health Insurance Claim Number (“HICN”), which is the number on the claimant’s Medicare card.\textsuperscript{50} Second, obtaining a benefits statement from the Social Security Administration by means of a search using the claimant’s first and last names, Social Security Number, and Social Security Consent Form signed by the claimant, or if a claimant fails or refuses to sign a consent form by means of a CMS “Query System.”\textsuperscript{51}

D. Information Reporting Entities Must Report When Medicare Eligibility Is Determined

Once the RRE has determined Medicare eligibility, it must report the claimant’s identity and other information necessary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.\textsuperscript{52} While specifics of the reporting data are contained in the GHP and non-GHP User’s Guides,\textsuperscript{53} requisite reporting information generally includes: the claimant’s name, address, date of birth, Social Security Number or HICN; the RREs name, address, policy type, Tax Identification Number, and policy number; the insured’s name; the date, nature, and cause of injury or incident; and, the settlement date and amount.\textsuperscript{54}
E. Timing For Reporting Entities To Report

The MMSEA requires that reportable information shall be submitted “after the claim is resolved through a settlement, judgement, award, or other payment.” Information must be submitted regardless of whether or not there is a determination or admission of liability.

F. Penalties For Reporting Entities’ Failure To Report

In addition to existing penalties under the Secondary Payer Act, an RREs’ failure to comply with the MMSEA’s requirements can result in penalties of $1,000 per day per claimant.

G. Forthcoming Implementation Of The MMSEA

Although its effective date is July 1, 2009, implementation of the MMSEA has been delayed. While RRE registration is open until September 30, 2009, training and testing runs from January 1 to March 30, 2010, and actual reporting does not begin until April 1, 2010.

Despite this delay in implementing the MMSEA, all existing Secondary Payer Act requirements (and penalties) remain otherwise in full force and effect for Responsible Reporting Entities. Therefore, in the context of personal injury liability claims, non-GHPs have an express obligation to report to Medicare if it knows that Medicare made a primary payment for services than the primary payer has made or should have made.

IV. PROTECTING MEDICARE’S INTERESTS IN PERSONAL INJURY CLAIMS

A. Despite A Lack Of CMS Guidance, Parties To A Liability Claim Must Reasonably Consider Medicare’s Interests In Resolving Those Claims

Enaction of the MMSEA now alleviates any previous uncertainty about the Secondary Payer Act’s application to personal injury liability cases, and Medicare’s role as a secondary payer in this context is certain. In the context of settling personal injury liability claims,
guidelines for compliance with the Secondary Payer Act’s expanded requirements are currently non-existent. However, the Secondary Payer Act still requires that the parties give reasonable consideration to Medicare’s interests, including its (1) past payments (i.e., its conditional Medicare payments) and (2) future Medicare-covered expenses. For past payments, Medicare reimbursements in liability cases will likely prove to be handled in a manner similar those of workers’ compensation claims. However, protecting Medicare’s interests in future costs is anything but clear.

B. Protecting Medicare’s Future Interests In Liability Claims Is Unclear

CMS has yet to provide any clear guidance on how to “reasonably consider” Medicare’s interests in liability claims. In light of the MMSEA and Secondary Payer Act’s imposing penalties, this lack of guidance and uncertainty is particularly troubling in the context of personal injury claims, especially with respect to future Medicare-covered costs and expenses. Until CMS issues guidance for personal injury liability claims, practitioners should consider looking to the workers’ compensation guidelines discussed above, following two general principles: (1) RREs must reasonably consider Medicare’s interests in settling personal injury liability claims, and (2) RREs must notify CMS of such claims.62

1. Use Of Set Aside Arrangements In Personal Injury Liability Cases

Several commentators have proposed a host of different strategies for protecting Medicare’s interests, including (1) interpleading an estimated amount of Medicare’s recovery entitlement; (2) characterizing the nature of the settlement proceeds as compensating non-economic losses; (3) seeking compromise with CMS; (4) waiting for an initial CMS demand letter; (5) specifying the party responsible for satisfying the Medicare reimbursement; (6) seeking
declaratory relief; and (7) endorsing Medicare and the beneficiary as payees on the settlement proceeds.63 However, each potential solution carries its own set of problems.64

While a Medicare Set Aside is not currently required in personal injury liability claims, commentators seem to uniformly agree that set aside arrangements provide the best approach to protect Medicare’s interests for future expenses in liability cases.65 Although CMS has no stated procedure to require and/or review set aside arrangements in personal injury cases, to the extent a liability settlement meets the appropriate criteria (i.e., the settlement is greater than $250,000 and the claimant has a “reasonable expectation” of Medicare enrollment within thirty months of the settlement date), then a set aside arrangement may an appropriate vehicle for reasonably considering Medicare’s interests in liability claims.66

2. Communication With CMS

While RRE notification of a claim is required, the reporting entity does not need claimant approval to do so.67 To protect their interests, RREs and practitioners should involve CMS in the settlement process as early as possible.68 Doing so may allow for negotiation of a favorable set aside amount with CMS.69 Of course, the negotiated amount must be sufficient to demonstrate that Medicare’s interests have reasonably been considered.70 What is more, it is only CMS—not a third-party contractor—who has the authority to compromise a Medicare claim.71

V. ALTHOUGH THE MMSEA IS FRAUGHT WITH UNINTENDED CONSEQUENCES, PRACTITIONERS HAVE MULTIPLE OPTIONS TO FACE THOSE CHALLENGES

A. The MMSEA Is Sure To Create Difficulties In Handling Personal Injury Liability Claims Involving Medicare Beneficiaries

The MMSEA now adds another device in CMS’ cost-shifting arsenal, and as a result,
claimants, RREs, and practitioners alike face a host of new challenges in resolving liability claims involving Medicare beneficiaries. Above all else, the MMSEA will prove to be a “roadblock” to settling liability cases.  

First, MMSEA compliance will undoubtedly increase the cost (and potentially reduce the likelihood) of settlement. Parties to liability claims will have to reasonably consider Medicare’s interests to avoid the Secondary Payer Act’s penalties. Medicare, especially if involved late or post-settlement, may have little or no ability to compromise the conditional payments and future expenses. Thus, what might otherwise prove to be a significantly compromised medical specials lien may now prove to be an extraordinary settlement impediment that must be overcome before a plaintiff will realistically consider settlement. As a result, defendants and Responsible Reporting Entities will be forced to either pay more to settle a case or resort to trial when a plaintiff will not accept an amount that will both satisfy Medicare’s full interest and compensate him or her for the alleged injuries. Under either scenario, the costs of resolving such disputes—to the detriment of the parties—will increase.

Second, plaintiffs (and their attorneys) will recover a lower amount than pre-MMSEA. By forcing plaintiffs to reimburse almost the full amount of their medical expenses—rather than a compromised amount—plaintiffs can expect to recover less.

Third, consideration of Medicare’s interests will likely slow the settlement process. With another entity involved—albeit one that is not even a party to the suit or claim—will only reduce the parties’ ability to quickly reach a settlement. If Medicare is involved before the settlement, communication with and feedback from CMS will no doubt introduce additional time and considerations into the negotiations. Moreover, if CMS is not involved until after the settlement,
the parties may not have certainty that Medicare will timely consider the settlement in a fashion that allows for quick closure of that process.

Finally, the MMSEA removes certainty from the settlement process. With CMS’ failure to provide any guidance regarding involvement in and approval of beneficiary settlements and/or set aside arrangements in liability cases, the parties, their attorneys, and their insurers are faced with entering into settlements that lack certainty due exposure from failure to timely reimburse Medicare and for failure to reasonably consider Medicare’s interests.\(^77\)

Aside from impeding settlement, the MMSEA has the potential consequence of reducing claimants’ access to representation. If plaintiffs’ attorneys working on a contingency fee basis are faced with the possibility of earning reduced fees by virtue of the plaintiffs’ obligation to reimburse Medicare in full, they may give serious consideration to declining representation of Medicare beneficiaries.\(^78\) What is more, in cases of highly disputed liability and/or cases in states where the plaintiff’s contributory negligence or assumption of the risk is a complete bar to any recovery, this unintended consequence may prove to be amplified.\(^79\)

**B. Potential Solutions To Overcoming Likely Problems Created By The MMSEA’s Expansion Of Secondary Payer Requirements**

A thoughtful practitioner can proactively take steps to reduce the risk of post-settlement or post-judgment exposure to MMSEA and Secondary Payer Act penalties and fines.

First, as discussed above, a threshold question is whether the Secondary Payer Act is even implicated. As with any personal injury case, an appropriate release for medical information, narrowly-tailored interrogatories, document requests, and subpoenas regarding the plaintiff’s injuries, social security number, HICN, medical costs and expenses, identification of the
Medicare secondary payer recovery contractor, and health care provider records will prove invaluable in determining whether and the extent to which Medicare’s interests must be reasonably considered.

Second, early and ongoing proactive involvement of CMS in the claim or suit may result in reducing the reimbursement costs to Medicare. While CMS may have little room to compromise its demand for reimbursement and set aside amounts after a settlement is reached, pre-settlement involvement and discussions with CMS may allow for significant reductions in the Medicare subrogation and/or set aside amounts.

Third, practitioners should advise their clients in writing that the plaintiff is a Medicare beneficiary, especially if the client is insured. Reporting entities’ failure to comply with reporting requirements can unnecessarily expose it to MMSEA’s onerous new penalties.

Fourth, at or before any mediation or settlement conference, practitioners should advise the mediator or neutral of the fact that the plaintiff is a Medicare beneficiary. Moreover, serious consideration should be given to discussing this issue among counsel before the mediation or settlement conference so as to ensure reasonable consideration of Medicare’s interests. Again, early consideration of Medicare’s interests can only help facilitate a more certain and favorable settlement at the mediation or settlement conference.

Finally, if a set aside arrangement is included as part of a settlement agreement, several provisions should be incorporated into the written settlement agreement. For example, the agreement should specifically reference the existence of a set aside arrangement, the amount of the arrangement, and the calculation for arriving at the set aside amount. Doing so will serve to demonstrate that the parties’ reasonably considered Medicare’s interests in resolving the
plaintiff’s claims, thereby protecting the claimants’ right to future Medicare payments and protecting the parties from exposure to the Secondary Payer Act’s onerous penalties.

VI. CONCLUSION

With enactment of the MMSEA, practitioners involved in representing parties in personal injury liability claims must now take significant, proactive but as of yet undefined steps to reasonably consider Medicare’s interests in resolving personal injury liability disputes involving Medicare beneficiaries. Moreover, insurers must now follow tedious reporting requirements in such cases. With enactment and implementation of the MMSEA, CMS now has vastly expanded powers in ensuring claimants, insurers, parties, and practitioners alike comply with those requirements or face harsh fines and penalties. For personal injury liability practitioners previously unfamiliar with this statutory scheme, the MMSEA will require an understanding of Secondary Payer Act compliance to ensure protection of their clients’ (and their own) interests.

2. 2/23/09 CMS Memorandum, p1.


4. 2/23/09 CMS Memorandum, p. 2.


6. MSP Manual, Ch. 1, §10.


8. 2/23/09 CMS Memorandum, p. 2.


10. 42 U.S.C. § 1395y(b)(2)(A), (B)(ii); 42 C.F.R.§ 411.24(b), (e).

11. 42 C.F.R. § 411.45(a)(2), 411.53(2).


16. FRANCO, p. 11.


18. 42 C.F.R.§ 411.37(a).

19. MSP Manual, Ch. 7, § 50.4.2.

21. WCMSA, pp. 1, 3.

22. 4/21/03 CMS Memorandum (Q2).

23. 4/22/03 CMS Memorandum (Q19).

24. 4/21/03 CMS Memorandum (Q20); MCWSA, p. 4.


27. WCMSA, p. 2.

28. 42 C.F.R. § 411.46(d)(2).

29. 4/22/03 CMS Memorandum (Q8).


32. 42 U.S.C. §1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24(b), (e).


34. 42 U.S.C. §1395y(b)(2)(B)(iii); 42 C.F.R. §411.24(g).

35. United States v. Harris, 2009 WL 891931 at * 3 (N.D.W. Va. 2009)(citing 42 C.F.R. § 411.24(g) and holding that plaintiff’s attorney in personal injury case was individually liable for reimbursing Medicare because it can recover “from any entity that has received payment from a primary plan,” including an attorney).

36. 42 U.S.C. §1395y(b)(2)(B)(ii)-(iii); 42 C.F.R. §411.24(c)(2), (h), (m).

37. 42 C.F.R. §411.24(c)(1).

38. 42 C.F.R. § 411.24(i).

39. 42 C.F.R. § 411.46(b).


42. 42 U.S.C. § 1395y(b)(7), (b)(8).


44. A “claimant” is an individual filing a claim directly against the applicable non-GHP, or an individual filing a claim against an individual or entity insured or covered by the applicable plant. See 42 U.S.C. § 1395y(b)(8)(D)(i)-(ii).


47. 42 U.S.C. § 1395y(b)(8)(F(i)-(iii).


49. CAMPBELL - MMSEA, p. 2.

50. CAMPBELL - MMSEA, p. 3.

51. CAMPBELL - MMSEA, p. 3.


54. CAMPBELL - MMSEA, p. 5.


60. 42 C.F.R § 411.25(a), (c); see United States v. Baxter, 345 F. 3d 866, 902 (11th Cir. 2003) (holding that primary payer had duty to inquire whether claimant was Medicare-eligible and that failure to inquire would result in primary payer as deemed to have knowledge, thereby triggering reporting obligation under 42 C.F.R § 411.25).

62. I.e., (i) is the claimant currently a Medicare recipient, or (ii) is the settlement is greater than $250,000 and does the claimant have a “reasonable expectation” of Medicare enrollment within thirty (30) months of the settlement date. See LITTLE, p. 593; BLACK, pp. 11-13; MCWSA memo, p. 4; Kelly, Heather, et al., “Medicare Reimbursement Problems,” For The Defense (Feb. 2008), p. 53 (hereinafter “KELLY”).

63. KELLY, pp. 12, 53.

64. KELLY, pp. 12, 53.

65. See LITTLE, p. 593; BLACK, pp. 11-13; MCWSA memo, p. 4; KELLY, p. 53.

66. WCMSA, p. 3.

67. 42 C.F.R § 411.25(a); 42 U.S.C. § 1395y(b)(8)(A)-(B).


69. MSP Manual, Ch. 7, § 50.4.2; CAMPBELL - GUIDE, p.1.

70. MSP Manual, Ch. 7, § 50.4.2; CAMPBELL - GUIDE, p. 1.

71. MSP Manual Ch 7, 50.4.2.

72. BLACK, p. 13; KELLY, pp. 10-11; LITTLE, p. 590.

73. KELLY, pp. 10-11; Swedloff, Rick, “Can’t Settle, Can’t Sue: How Congress Stole Tort Remedies From Medicare Beneficiaries,” 41 Akron L. Rev. 557, 600 (hereinafter “SWEDLOFF”).

74. SWEDLOFF, p. 600.

75. SWEDLOFF, p. 600.

76. SWEDLOFF, p. 600.

77. KELLY, p. 11.

78. SWEDLOFF, p. 600; BLACK, pp. 13-14.
79. SWEDLOFF, p. 600; BLACK, pp. 13-14.

80. FRANCO, pp. 10-11.

81. MSP Manual, Ch. 7, § 50.4.2.

82. 42 U.S.C. § 1395y(b)(8)(E)(i); 42 C.F.R § 411.25(a).

83. LITTLE, p. 593.

84. LITTLE, p. 593.

85. LITTLE, p. 593; BLACK, p. 12.