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PRODUCT LIABILITY UPDATE

New Requirement to Report Personal Injury Settlements and Payments to Medicare Beneficiaries

On July 1, 2009, new requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) become effective, and will impact almost every business that pays a settlement or judgment to a personal injury or wrongful death claimant. A paying entity will be required to determine whether the claimant is entitled to Medicare benefits and, if so, report information about the payment to Medicare.¹ *Failure to comply with the mandatory reporting requirement can result in a civil penalty of \$1,000 for each day of noncompliance per claimant.*² Under Section 111, a broad range of businesses facing personal injury tort claims will now be subject to the new obligations to “determine eligibility” and report. This bulletin provides an overview of the amendment. However, the new regulatory requirements are complex, and it is essential for every business entity that faces personal injury and wrongful death lawsuits and claims to review the requirements and procedures, and determine whether it is subject to the requirements.

NEW REQUIREMENTS APPLY TO ALL “SELF-INSURED” BUSINESSES

If Medicare pays medical expenses that should have been paid by a “primary plan,” Medicare is entitled to recover those payments from the “primary payer” and from “an entity that receives payment from a primary payer.” Until 2003, most courts considering Medicare reimbursement lawsuits ruled that Medicare was permitted to recover only from insurers, not tortfeasors that settle with and pay claimants from their own funds. But in 2003, Congress amended the Medicare as Secondary Payer Act (MSP) to expand the definition of the term “self-insured plan,” specifying that any “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.*” Construing the 2003 amendment, the Centers for Medicare & Medicaid Services (CMS), the federal agency charged with administering the Medicare program, provides that “individuals/entities engaged in a business, trade, or profession are self-insured to the extent they have not purchased liability insurance coverage. *This includes responsibility for deductibles.*”³ Thus, a business that pays a settlement or judgment, *including any deductible or co-pay*, to a tort claimant is deemed to be self-insured, even if the business can obtain reimbursement for some or all of its payment later from an insurer.

Self-insured businesses should prepare now for the new requirements, especially for certain preliminary actions that are required in advance of the July 1, 2009 effective date.⁴

NEW MANDATORY REQUIREMENTS OF SECTION 111

In an effort to enhance enforcement of Medicare’s reimbursement rights under MSP, Section 111 of the MMSEA adds new mandatory reporting requirements for liability insurance (including self-



insurance), no-fault insurance and workers' compensation. For self-insured businesses, as that term is defined above, the effective date for these new requirements is July 1, 2009. However, advance planning and action will be required by these businesses well before that date.

Briefly, Section 111 of MMSEA requires businesses paying personal injury settlements or judgments to a claimant to *determine* whether a claimant is entitled to Medicare benefits and, *if so, report* information about the payment to CMS in electronic format. But before a business entity can provide the required report to CMS, it must first register with CMS as a "responsible reporting entity" (RRE). All self-insured businesses are considered RREs.

Registering as an RRE

RREs must register with the Medicare Coordination of Benefits Contractor (COBC) *between May 1, 2009 and June 30, 2009*. Materials on the CMS web site indicate that businesses will need to complete the registration process "using a new, interactive, Web portal designed for this purpose." The web site will be located at <http://www.Section111.cms.hhs.gov>; however, according to the CMS, the web site is not yet available.⁵

Once an entity has registered, the COBC will email the RRE an assigned Section 111 Reporter ID (RRE ID), and the RRE must "fully test the data submission process before submitting production files." RREs then will be assigned a seven-day file submission timeframe during which they must submit reports each quarter. An RRE must complete the registration process itself, and may not use an agent to register (even though an agent may submit required reports on the RRE's behalf).

Obligation to Determine Medicare Beneficiary Status

As a rule of thumb, most U.S. citizens and permanent residents age 65 or older are, or may be, eligible for Medicare benefits, though actual Medicare eligibility is somewhat more complicated. Additionally, persons under age 65 also may be entitled to Medicare benefits if they have received Social Security Disability Insurance or Railroad Retirement disability benefits for 24 months or have end-stage renal disease.

CMS will establish a "query access" system to assist RREs in determining whether a claimant is entitled to Medicare benefits. Starting July 1, 2009, a registered RRE (or its designated agent) will be able to inquire, and Medicare will confirm, whether a claimant is a Medicare beneficiary. CMS will process one inquiry per month (which may include numerous claimants) per RRE ID.

Mandatory Duty to Report Payments to a Medicare Beneficiary

Because payments by tort defendants are incident-specific (unlike the ongoing payment responsibility of a group health plan or workers' compensation), "RREs are to report once there has been a settlement, judgment, award or other payment," provided the RRE determines that the claimant is (or deceased claimant was) entitled to Medicare benefits. Reports must be submitted during the assigned seven-day period for the calendar quarter, and must include the claimant's



Social Security number, along with other detailed information about the claimant, the injury and the payment.⁶ If the RRE determines that a claimant is not a Medicare beneficiary as of the date when its reports are due, it need not report the payment.

Once the RRE has registered, it may utilize an agent for submission of its subsequent required reports. Designation of an agent does not shift to the agent the RRE's reporting responsibility; the RRE remains solely responsible and accountable for complying with CMS instructions for implementing Section 111 and for the accuracy of data submitted by the agent.

The March 16, 2009 User Guide provides detailed amplifying and clarifying information regarding reporting requirements. A few of the requirements are worth highlighting here:

- The RRE must report the full amount of its settlement, judgment, award or other payment. If medical expenses are *claimed or released*, an RRE cannot avoid its reporting requirement by agreeing with the claimant that “no medicals” are being paid. CMS is not bound by any allocation by the parties of the amounts paid, even if the court has approved such an allocation. While there is the potential for Medicare to demand reimbursement for treatment of conditions unrelated to the injury involved in the tort claim, there is a procedure for challenging expense items as being unrelated to the tort injury. Medicare bears the ultimate burden of proving in litigation that the claimed expenses are related to the tort injury or illness.
- When multiple defendants are involved in a settlement, judgment, award or other payment, each RRE involved is responsible for its own reporting. The defendants cannot avoid this responsibility by agreeing to have one of them, or one of their insurers, issue the payment in satisfaction of the settlement, judgment, award or other payment.
- Currently, there is no exception to the reporting requirements for alleged de minimus or “nuisance” settlements or other payments, though CMS is considering adopting such an exception.
- RREs must report settlements, judgments, awards or other payments regardless of whether there has been an admission or determination of liability (and even if they disputed liability).
- *Exception for Certain Claims Involving “Exposure.”* Because the liability insurance provisions of MSP became effective December 5, 1980, CMA has determined as a matter of policy that it will not seek recovery under the MSP provisions where the date of incident, as defined by CMS, was prior to December 5, 1980. For claims involving “exposure” (presumably, to a toxic substance or environment), if there was no exposure of the claimant “on or after December 5, 1980, alleged, established and/or released,” then there is *no obligation to report* the settlement or payment. In a joint settlement by multiple defendants, some defendants may be required to report their payments while others may be able to take advantage of the “exposure” exception.

PROTECTING YOUR COMPANY FROM POTENTIAL MSP REIMBURSEMENT LIABILITY

If a self-insured business learns that a claimant is a Medicare beneficiary, one method to reduce the risk of later liability to Medicare is to name three payees on the settlement check: the claimant, the



claimant's attorney and Medicare's contractor (currently, MSP Recovery Contractor, *see* <http://www.msprc.info/>). This should ensure the Medicare contractor can satisfy Medicare's reimbursement rights from the proceeds of the settlement. This procedure does not eliminate the payer's responsibility to report its payment as required by Section 111 of MMSEA.

CONCLUSION

Given the upcoming RRE registration period of May 1 to June 30, 2009, and the mandatory initial reports coming due in the fourth quarter of 2009, businesses defending personal injury and wrongful death lawsuits and claims should inform themselves now about the new requirements and, if applicable, implement procedures to comply with the law. With penalties of \$1,000 per day per claimant for failure to report payments to Medicare beneficiaries, businesses simply cannot afford to ignore the requirements of MMSEA Section 111.

FOR MORE INFORMATION

For more information on this topic, please contact:

Harold W. Henderson	216.566.5779	Hal.Henderson@ThompsonHine.com
Joshua A. Klarfeld	216.566.5902	Joshua.Klarfeld@ThompsonHine.com

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¹ 42 U.S.C. § 1395y(b)(8)(A).

² *Id.*

³ MMSEA Section 111 Medicare Secondary Payer Mandatory – User Guide, available at <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf> ("March 16, 2009 User Guide") (emphasis added).

⁴ The CMS maintains a web site describing the requirements and procedures soon to go into effect. *See* <http://www.cms.hhs.gov/MandatoryInsRep> ("CMS web site"). Additionally, the March 16, 2009 User Guide contains the most up-to-date version of the CMS's guidance on the amendment.

⁵ RREs are not required to register if they will have nothing to report. If, for example, a business is self-insured solely for the deductible of a liability insurance policy, but it always pays the deductible to its insurer, who then pays the claimant, the business is not required to report. Nonetheless, those entities that do not register initially because they have no expectation of having claims to report, still *must* register in time to allow a full quarter for testing if they encounter future situations where they have a reasonable expectation of having to report.

⁶ Details on the required data for reports are spelled out in the 180-page March 16, 2009 User Guide.