By-Lined Article

MEDICARE SECONDARY PAYER STATUTE: NEW REPORTING REQUIREMENTS FOR PRODUCTS LIABILITY AND TOXIC TORT CLIENTS

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Beginning January 1, 2010, extensive new Medicare reporting obligations will apply to insurance companies and other businesses, including products liability and toxic tort defendants that make payments to Medicare beneficiaries as a result of verdicts or settlements resolving liability claims. These organizations — known as Responsible Reporting Entities ("RREs") — will be required to report virtually all settlements, judgments, awards, and other resolutions of claims establishing responsibility for payments to Medicare beneficiaries, so that Medicare may determine whether it has a stake in any part of the payment. The reporting will also enable Medicare to refuse payment for future medical care relating to the injuries that were the subject of the liability claim. Failure to report may result in significant financial penalties against the RRE.

Congress established these reporting obligations in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"), codified at 42 U.S.C. Section 1395y (b)(8). Section 111 of MMSEA requires RREs to report any payment obligation to a Medicare beneficiary when the obligation results from a claim potentially involving past or future medical expenses. RREs must notify Medicare, regardless of whether there is an admission of fault, and must provide Medicare the total amount to be paid by the RRE — including compensatory and punitive damages, as well as payments made to spouses. Although Medicare will consider the allocation of damages agreed to by the parties or that made by a court, Medicare takes the position that it is not bound by these allocations and is free to recover amounts in excess of those designated for medical expenses by a court or settlement agreement.

Organizations should immediately determine whether they are an RRE under the statute and, if so, promptly register with the Centers for Medicare and Medicaid Services ("CMS") and implement procedures to ensure that all payment obligations to Medicare beneficiaries established on or after January 1, 2010, are properly reported to CMS. Section 111 imposes substantial civil penalties on RREs that do not report payments to Medicare beneficiaries. The statute provides for penalties of up to $1,000 per day for each claim that an RRE does not report. Although the September 30 deadline for RREs to register with CMS has passed, RREs that missed the deadline can still register online.

Uses of Information

Medicare has indicated that it will use the information from RREs in two ways. First, Medicare will use it to recover benefits it had previously paid for the treatment of the injury for which a plaintiff was compensated. Although this right of recovery has existed since the 1980s, there has never been an efficient mechanism for Medicare to learn of payments to beneficiaries and initiate the recovery process. The new MMSEA reporting requirements are expected to significantly enhance Medicare's ability to recover payments for medical care furnished to beneficiaries that receive compensation for their injuries.

Additionally, RRE submissions will allow Medicare to more effectively deny payment on future medical claims related to the injury for which the beneficiary was compensated. RREs are initially required to provide a narrative description of the plaintiff's alleged injury, but within two years will be required to provide ICD-9 diagnoses and cause of injury codes to CMS. This information will allow Medicare to deny claims that it determines are related to the prior injury and will likely have the effect of increasing settlement demands, as plaintiffs will no longer be able to assume that Medicare will pay their future medical expenses related to the injury. Although there has been no substantive change to Medicare's right to deny future claims if a primary payer exists, Medicare has lacked until now a comprehensive database with the necessary information to recover past payments or deny new medical claims.

Discovery

Defense counsel should consider amending their interrogatories to determine, at the beginning of a case, whether a plaintiff is a Medicare beneficiary or when the plaintiff expects to begin receiving Medicare benefits. Interrogatories may also seek information about the plaintiff's Medicare Identification Number, when Medicare entitlement began, and whether any claims for the plaintiff's medical care related to the injuries alleged in the lawsuit have been paid by, or filed with, Medicare. Medicare has recognized that RREs, such as products liability defendants, will need a way to determine whether a plaintiff is a Medicare beneficiary, so CMS has developed a system that allows registered RREs to query a database of Medicare beneficiaries at any time. This is an important tool, and RREs should query the name of every plaintiff through the Medicare beneficiary database periodically and, most importantly, at the time when a settlement is negotiated or a verdict is reached.

For latent diseases, such as asbestos-related conditions, the new reporting requirements increase the importance of determining the dates of exposure to the allegedly toxic substances. CMS has determined that only claims resulting from at least one post-December 5, 1980, exposure are reportable under the MMSEA requirements. Therefore, defense counsel

should use discovery to determine the exact dates of exposure, but the significant penalties for failing to report a claim suggest that defendants should err on the side of caution and report all claims where the dates of exposure are ambiguous.

Settlements

At this time, there are concerns about the confidentiality of settlement agreements, as Medicare regulations require that the existence and amount of all settlements be reported, regardless of whether the parties kept the agreement confidential. Although some commentators have speculated that settlement amounts may be available via Freedom of Information Act requests, there is no precedent suggesting that Medicare would voluntarily turn over this information. Such data may be protected from routine disclosure by CMS under the Health Insurance Portability and Accountability Act and the Privacy Act. Rather, a bigger concern is that the terms of a confidential settlement may become public if Medicare is required to take legal action to recover payments it made prior to the settlement. Medicare would likely use the settlement amount and other information reported to CMS by the RRE, and possibly the settlement agreement itself, if available, as evidence in its suit. It is also possible that the information reported by a RRE could be made public during a Medicare beneficiary's administrative appeal or lawsuit contesting a denial of benefits based on a submission of an RRE.

The new MMSEA reporting requirements will also likely make it difficult for defendants to settle claims where Medicare has already paid a significant amount towards the plaintiff's medical care for the injury that is the subject of the litigation. This might be especially true in instances where the plaintiff has significant injuries but the defense on causation is strong and the defendant has been willing only to make a negligible settlement offer to resolve the matter. Plaintiffs may also be unwilling to settle claims if there is a possibility of significant ongoing medical expenses, as Medicare will know of the settlement and will likely refuse to pay any claims relating to the injury that was the subject of the settlement. In these cases, plaintiffs may prefer to try the case, hoping that Medicare will respect the allocation made by a judge or a jury between medical expenses and compensatory damages, punitive damages, loss of consortium, etc. The MMSEA Section 111 User Guide by CMS currently states that "[t]he CMS is not bound by any allocation made by the parties even where a court has approved such an allocation. The CMS does normally defer to an allocation made through a jury verdict or after a hearing on the merits." (CMS MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting User Guide, at 76). Plaintiffs may begin to try cases where there is the prospect of significant future medical expenses, as it is possible that Medicare will begin paying for medical claims related to the suit after the verdict's allocation for future medical expenses is exhausted.

If there are any prior payments by Medicare relating to the injury that was the subject of the suit, then attorneys on both sides should ensure that the Medicare right of reimbursement is satisfied before the plaintiff receives any money. Every settlement agreement should clearly delineate which party is responsible for confirming the amount of any Medicare payment and reimbursing this amount in its entirety — typically the plaintiff is in the best position to do so. Defendants should ensure that any Medicare right of reimbursement related to the injury alleged in the suit is satisfied in full, since CMS takes the position that the Medicare primary payer ultimately remains liable for any unpaid Medicare lien.

MMSEA imposes significant, and expensive, burdens on products liability and toxic tort defendants, as well as their insurers. As there are significant financial penalties for noncompliance, all organizations should immediately determine if they are an RRE under the statute. If so, RREs should immediately register with CMS and take the necessary steps to ensure that they are able to comply with the reporting requirements by January 1, 2010.

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