

CUOMO LLC

NYC OFFICE: 9 EAST 38TH STREET | 3RD FLOOR | NEW YORK, NY 10016 | TEL: 212.448.9933 | FAX: 212.448.9943

THE MEDICARE, MEDICAID AND SCHIP EXTENSION ACT OF 2007

INTRODUCTION

In 2007 Congress enacted the Medicare/Medicaid and SCHIP Extension Act (the "2007 Act"). Many in the liability insurance sector were left puzzled by the requirements put in place by this law. Initially many assumed that the new law gave Medicare a right of recovery against liability insurers should a plaintiff, who has received benefits for Medicare, not reimburse Medicare. However, the 2007 Act did not create Medicare's right of reimbursement. Instead, the 2007 Act has stringent electronic reporting requirements that are intended to enable Medicare's Coordination of Benefits Contractor (COBC) and the Medicare Secondary Payer Recovery Contractor (MSPRC) to identify situations in which a plaintiff, plaintiff's attorney and/or liability insurer may be responsible for reimbursing Medicare for payment or conditional payment made by Medicare on behalf of that plaintiff.

MEDICARE IS A SECONDARY PAYER

Prior to 1980 Medicare was a primary payer to private health insurance plans or any other source of coverage for injuries or illness. In 1980 Congress enacted the Medicare Secondary Payer Act (42 USC § 1395(y)) (the "MSP Act"). When the MSP Act was adopted it was initially assumed that Medicare providers, suppliers and/or claimants should submit claims to applicable primary health insurers before submitting them to Medicare. It was understood that Medicare could seek reimbursement from group health plans when Medicare could demonstrate that the Medicare eligible person had a group health plan that should have been primary to Medicare. It was also understood that a plaintiff who had an injury claim involving a no-fault carrier, liability carrier or Workers' Compensation should seek primary payment for treatment related to the injuries alleged, from those insurers, and that Medicare would have a lien against the plaintiff's recovery to recoup the cost of Medicare benefits paid on behalf of that plaintiff.

However, approximately 20 years later, Medicare acted on the position that it could seek direct reimbursement from Workers' Compensation, no-fault, liability insurers and tort defendants as well. Medicare was now interpreting the MSP Act not as simply creating a priority whereby Medicare would be a secondary payer, but as also giving Medicare, in any scenario where it paid, the right to pursue reimbursement from a liability insurer or a tort defendant.

CUOMO LLC

The watershed case in Medicare's effort to seek reimbursement from tort defendants and/or liability insurers is United States v. Baxter Int'l, Inc., 345 F.3d 866 (11th Cir. 2003). In Baxter, Medicare attempted to recover Medicare payments made to claimants in a 400,000 class member settlement involving breast implant litigation. The 11th Circuit determined that Medicare was a secondary payer with respect to self-insured tort defendants and liability insurers and therefore had a direct right of action against those tort defendants and/or their liability carriers to be reimbursed for Medicare benefits paid to any plaintiff in the class (if the benefits were related to treatment associated with the breast implants).

Thereafter, in 2003 Congress adopted the Baxter holding in the Medicare Prescription Drug Improvement and Modernization Act of 2003 (the "2003 Act"). These amendments statutorily codified Medicare's right to recover from the plaintiff's settlement proceeds as a lien or as reimbursement from a tort defendant and/or its liability insurance carrier.

Pursuant to the 2003 Act, the tort defendant and/or its liability insurer may pay twice, once to the plaintiff and once to Medicare. That's right, the liability insurer may wind up paying Medicare even if it has already paid the plaintiff and received a release from the plaintiff. Further, if the MSPRC must institute suit to recover from the liability insurer, the insurer may be required to pay three times the amount of benefits: once to the plaintiff, and double the amount of benefits to the government (as the statute provides for a doubling of the reimbursement if the MSPRC is required to initiate suit to obtain reimbursement).

However, notwithstanding this potential exposure, most liability insurers paid no mind to the 2003 Act because Medicare was largely unable to determine when Medicare recipients were also plaintiffs in liability lawsuits and hence, was largely unable to enforce its position as a secondary payer.

THE REPORTING REQUIREMENT: THE MEDICARE/MEDICAID SCHIP EXTENSION ACT OF 2007

Although Medicare has been deemed a secondary payer since 1980, there is no doubt that since 1980 billions of dollars have been expended by Medicare for the treatment and care of injuries which were sustained in the work place, in automobile accidents or in many different manner of incidents that give rise to tort lawsuits. The intent of the MSP Act was to shift the cost burden from the government to the private sector. However, over the last three decades, the lack of any system by which Medicare could track these types of claims left it largely unable to pursue its right to be a secondary payer.

CUOMO^{LLC}

The 2007 Act is Congress's attempt to address that situation. In short, entities who may be responsible to reimburse Medicare, and particularly liability insurers, are designated as Responsible Reporting Entities (RREs). They are required to register with and to electronically transmit claim data to COBC. COBC will use the data to determine when Medicare should pay secondarily to some other source of coverage (such as liability coverage) and when Medicare should make conditional payments subject to reimbursement either by lien against the plaintiff's recovery or reimbursement from the liability insurer. Please note that as of this date, the reporting requirement for non-group health plans, which includes liability insurers, Workers' Compensation insurers and no-fault insurers has been pushed back to January 1, 2011 because of a lack of guidance on reporting requirements.

The 2007 Act requires liability insurers to first determine a claimant's Medicare eligibility. The specific assessment to be made is whether the claimant is reasonably expected to become eligible for Medicare benefits within 30 months of the conclusion of the claim. If so, the RRE must submit particular information through an electronic reporting system to Medicare.

Eligibility information may be obtained in two ways. The first option is to make an inquiry of the Medicare system by providing the name, date of birth, social security number to ISO. ISO will send a file to the Center for Medicare and Medicaid Services (CMS) monthly for each registered RRE. CMS will respond in one of three ways: (1) the plaintiff is Medicare eligible; (2) the plaintiff is not eligible; or (3) that there is an error in the file indicating some incorrect information. It is important to note that if Medicare reports that the plaintiff is not Medicare eligible that does not absolve the RRE from reporting if, in fact, the plaintiff is Medicare eligible.

The second way in which to obtain information about the plaintiff's Medicare eligibility is to obtain the required information from the plaintiff. In this regard, we suggest that defense counsel prepare a discovery demand, which elicits information from the plaintiff which will enable a determination of Medicare eligibility to be made. Defense counsel should be directed to share all Medicare eligibility information with the claims adjuster as soon as it is obtained from plaintiff. Likewise, if the matter is not in suit, it is incumbent upon the claims adjuster to obtain Medicare eligibility information from the plaintiff and/or plaintiff's attorney so that an eligibility determination may be made to determine whether there is a reporting obligation. Provided herewith is an exemplar of a notice of discovery and inspection that can be used by defense counsel. A similar demand, by letter, may also be used by a claims adjuster, in the pre-suit stage.

CUOMO^{LLC}

Regarding the frequency and timing of reporting, there are several factors to be taken into account. First, the COBC will assign each RRE a quarterly reporting timeframe. Upon registration, the RRE will be assigned a group number which determines the week within the first, second or third month of the quarter that the RRE's reports will be required to be filed.

Certain claims may require multiple reporting during their lifespan. These are claims which involve Ongoing Responsibility for Medicals (ORM) in addition to Total Payment Obligation to the Claimant (TPOC). However, these multiple payment types of claims will generally be related to Workers' Compensation and no-fault claims. To the extent a claim handled by a liability insurer involves a single payment claim to the claimant, meaning that there is only one TPOC settlement, judgment, award, verdict or other payment to the claimant, it will be reported only once regardless of whether it is funded through a single payment, an annuity or structured settlement. In that situation, the report will be required within the quarter following the payment.

Payment should never be made before Medicare eligibility is determined. First, plaintiff and plaintiff's counsel may lose any desire to cooperate with respect to providing Medicare eligibility information once plaintiff has the money. Further, if a report is not made within the required time frame, the RRE will be subject to a civil money penalty of \$1,000.00 for each day of non-compliance with respect to that claim. Hence, it is better practice for claims adjusters and defense counsel to obtain Medicare eligibility information early on in the claims/litigation process before they lose leverage over plaintiff and plaintiff's counsel. From a practical perspective, once the RRE is registered and has gone through the process of setting up its interface with CMS, it may be easiest to report all claims involving any type of injury.

Further, be aware that the civil penalty for failure to report, is a separate exposure from the potential requirement to reimburse Medicare. If an RRE fails to report in a timely manner, it will be subject to the civil money penalty. If Medicare is unable to obtain its reimbursement through its lien against the plaintiff's settlement or obtain those funds from the plaintiff's attorney, it still has a separate and distinct right of reimbursement and the right to commence a direct action against a liability insurer for reimbursement. Additionally, even if an RRE timely and correctly submits reports and is not subject to the civil money penalty, that does not provide a safe harbor against a recovery action by the MSPRC.

CUOMO^{LLC}

HOW CAN THE LIABILITY INSURER PROTECT ITSELF AND ITS INSURED?

In light of this statutory framework, it is vital to understand how best to avoid reimbursement exposure when settling with a plaintiff who is, or may within the 30 months following payment, become eligible for Medicare. In this regard, it is interesting to note that, other than Workers' Compensation claims, there is no requirement of a set-aside for Medicare reimbursement purposes at the time of settlement. Likewise, there is no requirement to involve COBC to address coordination of benefits issues. That leaves the liability insurer on its own to best determine how to avoid potential reimbursement situations. If no action is taken the liability insurer is just left hoping that the plaintiff and/or plaintiff's attorney will sequester the requisite funds required to reimburse Medicare and take responsibility for reimbursing Medicare. Although it is assumed that reimbursement will be sought primarily from plaintiff and plaintiff's attorney there is nothing in the statute that requires the MSPRC to first attempt to obtain its recovery as a lien against the plaintiff or direct action against the plaintiff's attorney.

Hoping the plaintiff and the plaintiff's attorney will satisfy Medicare obligations is not the best way to protect the liability carrier and its insured from reimbursement actions. Instead we have a series of suggestions related to settling claims with Medicare recipients.

First, all defense counsel and claims adjusters must endeavor, as early as possible in the claim process, to determine whether the plaintiff is Medicare eligible. In this regard, it is important to remember that not only those over 65 qualify for Medicare. Reporting is required if there is a reasonable expectation that the plaintiff will become eligible within 30 months after the payout. Therefore identifying plaintiffs over 62 ½ years old will be imperative as they would reach the age of 65 within 30 months of payment. Other triggers for eligibility or potential eligibility are when the plaintiff is collecting Social Security disability benefits or has been denied Social Security disability benefits and has appealed that denial. The final category of those who may be Medicare eligible are those who have a diagnosed End-Stage Renal Disease. Our suggested notice for discovery and inspection specifically requests information related to these eligibility or potential eligibility categories. If the matter is not in suit and/or defense counsel has not been assigned, the claims adjuster can use the demands set forth in exemplar notice as the basis for demands for information set forth in letter form.

Further, although an inquiry can be made of Medicare as to whether plaintiff is Medicare eligible, a false negative does not insulate the liability insurer from the reporting requirements and the civil money penalties associated with failing to report. Therefore, although inquiries to Medicare should be processed, the liability insurer and defense counsel should make the most robust efforts to obtain information from plaintiff and plaintiff's counsel with respect to the plaintiff's Medicare eligibility. Further, although the reporting requirements can be contracted out to third-parties, the responsibility for reporting and for any penalties associated with failure to report still rests with the RRE (the liability insurer).

CUOMO LLC

Finally, if it is determined that a plaintiff is Medicare eligible the insurer must not settle the claim with the plaintiff without obtaining specific protection against a Medicare reimbursement claim. Although the RRE cannot avoid the government's claim, it can shift the risk, through appropriate agreements and/or actions, to plaintiff and plaintiff's counsel.

Among the strategies which may be employed to shift and keep the risk with plaintiff and plaintiff's counsel are the following:

1. plaintiff's attorney must make a specific representation, in writing, concerning the amount that has been paid by Medicare for injury related treatment and diagnosis; and,
2. plaintiff's attorney and the plaintiff, jointly and severally, agree to indemnify the insured, liability insurer and defense counsel against any lien or recovery actions by Medicare and/or its contractor, MSPRC. (A sample of a hold harmless and indemnity agreement is provided herewith); and/or,
3. the settlement check can be made payable to plaintiff, her attorney and Medicare; and/or,
4. the settlement can be disbursed in two checks; one payable to the plaintiff and the attorney and a second payable to Medicare for the amount of reasonably confirmed Medicare benefits; and/or,
5. the liability insurer can hold a sufficient amount of the settlement proceeds in trust pending a resolution of the Medicare reimbursement claims; and/or,
6. some combination of the above.

Please call us for more information

We hope this pamphlet has been helpful. If you would like to discuss this issue, or any other matter, please call us at (212) 448-9933. In addition, please visit our website at www.cuomollc.com for further information about our firm.

© 2010 Cuomo LLC

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF RICHMOND

-----X
JANE DOE,

Plaintiff,

-against-

JOHN SMITH,

Defendants.
-----X

DEMAND FOR
MEDICARE AND
SOCIAL SECURITY
DISABILITY
INFORMATION

Index No.:

PLEASE TAKE NOTICE that, pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (42 U.S.C. § 1395y(b)(8)), the undersigned hereby demands that the plaintiff produce at the offices of the undersigned, 9 East 38th Street, New York, New York 10016 within twenty (20) days of receipt of this demand for copying, testing, examining, inspecting and photographing the following items:

1. State whether the plaintiff has ever received benefits from Medicare at any time for any reason not limited to the injuries alleged in the instant action.
 - a. If so, please provide the plaintiff's Medicare identification number; and,
 - b. a duly executed HIPAA compliant authorization permitting defense counsel to obtain copies of the plaintiff's Medicare file.
2. State whether the plaintiff has ever applied for Social Security disability benefits.
 - a. If so, state whether the application was granted or denied and if granted, please provide any claim or identification number assigned by the Social Security Administration; and,

- b. If the application was denied, state whether the plaintiff has appealed or is appealing therefrom, and/or if s/he is or has re-filed for Social Security disability benefits; and,
 - c. If the plaintiff has answered yes to any portion of demand number 2, please provide duly executed HIPAA compliant authorizations permitting defense counsel to obtain copies of the plaintiff's Social Security disability and Medicare files.
3. State whether the plaintiff has end-stage renal disease.
 4. Provide the plaintiff's social security number.
 5. Provide the plaintiff's date of birth.
 6. State the plaintiff's gender.
 7. Provide the plaintiff's full legal name as reflected on his/her social security card.

PLEASE TAKE FURTHER NOTICE that this demand shall be deemed to continue during the pendency of this action. In the event that the plaintiff's response(s) change and/or materials become available after the designated date, the plaintiff is required to supplement or amend his/her response accordingly.

PLEASE TAKE FURTHER NOTICE, that in lieu of personal appearance, the plaintiff may submit to the undersigned true and complete copies of the items demanded at any time on or before the above-mentioned date.

Dated: New York, New York
April ____, 2010

DEFENSE COUNSEL

By: _____

TO: Plaintiff's Counsel

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

-----X
JANE DOE,

Plaintiff,

-against-

JOHN SMITH,

Defendants.
-----X

HOLD HARMLESS
AGREEMENT

Index No.:

IT IS HEREBY STIPULATED, AGREED and WARRANTED, by and on behalf of the plaintiff in this action, in consideration of the settlement of his action by **insured/defendant** as follows:

1. Plaintiff and Plaintiff's counsel will defend, indemnify and hold harmless, all at their cost, **insured/defendant, defense counsel and insurance carrier**, and any insuring entity participating in this agreement, against any lien, or claim or action related to any lien, arising from the settlement or asserted against the settlement proceeds.

2. Plaintiff and Plaintiff's counsel will defend, indemnify and hold harmless, all at their cost, **insured/defendant, defense counsel and insurance carrier**, and any insuring entity participating in this agreement, against any lien, demand, claim, action and/or proceeding of any nature whatsoever, presented or otherwise instituted by Medicare, its contractor, the Medicare Secondary Payer Recovery Contractor, and/or the Center for Medicare and Medicaid Services ("CMS"), for reimbursement or repayment of benefits paid to or on behalf of Plaintiff and/or for enforcement of Medicare's position as a secondary payer.

3. Plaintiff and Plaintiff's counsel will have the sole responsibility to satisfy any lien or claim asserted against the settlement proceeds or arising from the settlement.

4. Plaintiff and Plaintiff's counsel will have the sole responsibility to satisfy any Medicare lien or claim asserted by Medicare, its contractor, the Medicare Secondary Payer Recovery Contractor and/or the Center for Medicare and Medicaid Services ("CMS") against the settlement proceeds or arising from the settlement.

5. Plaintiff makes no claim against any other defendant in this action for vicarious liability for any alleged acts or omissions of *insured/defendant*.

6. Plaintiff and Plaintiff's counsel will hold harmless any insuring entity participating in this settlement, and *insured/defendant, defense counsel and insurance carrier*, on any claim or action for contribution, indemnification or subrogation arising out of any act or omission of *insured/defendant*.

7. Plaintiff will completely satisfy all claims Medicare, Medicaid, the Medicare Secondary Payer Recovery Contractor and/or the Center for Medicare and Medicaid Services ("CMS") may have with respect to the settlement of this action and the claims asserted in this action by paying all funds due and owing to Medicare and/or Medicaid, within sixty (60) days of receipt of the settlement proceeds.

8. The settlement of this action does not constitute any admission of liability on the part of *insured/defendant* or any insuring entity participating in this settlement.

Dated: New York, New York
April __, 2010

Plaintiff

Plaintiff's Counsel