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Business Insurance

Secondary payer law creates challenges

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Failure to comply with the Medicare, Medicaid and SCHIP Extension Act of 2007 and the Medicare Secondary Payer Act could be costly for all parties involved in litigation or claims filed by Medicare beneficiaries, says Iman Soliman, an attorney with law firm Bowman and Brooke L.L.P. in Phoenix. Those potentially affected should see the Centers for Medicare & Medicaid Services' Web site and get legal advice to put a system in place that complies with the law, she says

Beginning in January, Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 will require every responsible reporting entity to report detailed information on all personal injury lawsuits and claim payments to Medicare beneficiaries.

Moreover, within 60 days after any such payment, the Medicare Secondary Payer Act will require parties to a claim to reimburse the federal government for any medical expenses paid by Medicare as a secondary payer.

Who is a responsible reporting entity? An RRE is any entity that pays or funds, in whole or in part, any settlement, judgment, award or other monies to a Medicare beneficiary for medical expenses paid by Medicare as a secondary payer.

When is Medicare a secondary payer? Medicare is a secondary payer whenever it pays medical expenses for which liability insurance plans, private self-insured entities, no-fault insurance or group health plans were primarily responsible. Generally, for example, Medicare is a secondary payer when it pays the medical expenses of Medicare beneficiaries who:

- are 65 years old or older and have group health care coverage of their own or through a spouse's employer, if the employer employs at least 20 employees;
- are disabled and have group coverage through their or a family member's employer, if the employer employs at least 100 employees;
- or are diagnosed with end-stage renal disease and have group coverage on any basis. Medicare is secondary to group coverage for a 30-month "coordination period."

How does an RRE determine if Medicare is a secondary payer? Generally, Medicare-eligible persons include individuals 65 years old or older, certain disabled individuals, and individuals with permanent kidney failure. Eligibility is not limited to just those persons 65 or older; indeed, AARP estimated that 16% of Medicare beneficiaries in 2003 were younger than 65.

An RRE may ask people who file personal injury lawsuits or claims about their Medicare eligibility. However, it is not recommended that RREs rely solely on claimant responses. The best way to determine if a claimant is a Medicare beneficiary is to submit electronically a verification query to the Centers for Medicare & Medicaid Services, the federal agency that oversees Medicare, which must respond to the query within 14 days. To submit a query, an RRE must send the Social Security number, name, date of birth, and gender of the claimant on a secure Web site.

What information must an RRE report? An RRE must electronically report to CMS' coordination of benefits contractor up to 100 categories of information about any Medicare beneficiary to whom the RRE pays or funds, in whole or in part, any judgment, settlement, or other monies totaling more than $5,000 in 2010, more than $2,000 in 2011, and more than $600 in 2012 and thereafter. The report must be made when the claim is resolved and when a payout is made or will be made in the future. If the RRE is the party responsible for the payout, the RRE must report it to CMS upon final resolution of the claim.

An RRE must report to the coordination-of-benefits contractor even if there is no determination of fault or liability for the payment. A disclaimer of liability within a settlement agreement does not relieve an RRE of its reporting requirement. Similarly, a statement in the settlement agreement or a court order approving the settlement that there are "no medicals," or that the settlement does not include monies

for medical expenses, does not eliminate the reporting requirement if the claimant alleged medical expenses in the claim as originally filed.

An RRE who fails to comply with the Section 111 may be fined up to $1,000 per day for noncompliance.

When must Medicare be reimbursed after an RRE payment? A Medicare beneficiary has 60 days to reimburse the federal government for medical expenses paid by Medicare as a secondary payer. Failure to reimburse within 60 days may result in an interest penalty on the outstanding amount. Failure to reimburse also may result in legal action under the Medicare, Medicaid and SCHIP Extension Act, which grants CMS an independent cause of action against anyone who fails to reimburse the agency. If CMS initiates legal action, it is entitled to recover "double damages," or twice the payments made on behalf of the Medicare beneficiary.

Failure to comply with the Medicare, Medicaid and SCHIP Extension Act and Medicare Secondary Payer Act could be a costly mistake for all parties—plaintiff and defendant—involved in litigation or claims filed by Medicare beneficiaries. Accordingly, individuals and entities potentially affected by the Medical Secondary Payer Act should visit CMS' Web site at *www.cms.hhs.gov* for detailed information and seek an attorney's advice about putting a system in place to comply on time or about particular issues to avoid penalties.

Iman Soliman is an attorney with the national litigation firm Bowman and Brooke L.L.P.. She focuses her practice on defending clients in claims arising out of alleged product defect and employment law claims, such as those involving employee health care coverage. Ms. Soliman practices from the firm's Phoenix office.