NAVIGATING THE UNCHARTED WATERS OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT

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Fall 2009 CLE

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The Maritime Law Association of the United States
Fall Meeting, November 2009
Hilton Head, South Carolina

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I. Introduction

On December 29, 2007, President George W. Bush signed into law the Medicare, Medicaid and SCRIP Extension Act of 2007,[1] effectively requiring liability insurers, including self insured companies, to report to the federal government all payments to a Medicare beneficiary via settlement, judgment, award, or otherwise. The law provides that, as of July 1, 2009, such insurers and companies shall be responsible for determining whether a personal injury claimant is a Medicare beneficiary, and upon resolution of claims involving payment to a Medicare beneficiary, report the results to the Centers for Medicare & Medicaid Services ("CMS").[2] The law carries stiff penalties for those responsible entities who fail to report such claims, and thus protect Medicare's right to reimbursement. Although the law has applied for decades in the resolution of workers' compensation claims, it is relatively new to civil tort practice, and practitioners of personal injury law are encouraged to familiarize themselves with the new regulations.

II. Legislative History

In the summer of 1965, President Lyndon B. Johnson signed into law The Medicare Act,[3] which was intended to insure availability of adequate medical care to the aged.[4] At the bill-signing ceremony President Johnson enrolled President Harry S. Truman as the first Medicare beneficiary and presented him with the first Medicare card. Today, Medicare is the nation's largest health insurance program, covering nearly 40

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[1] Pub. L. No. 110-173, 121 Stat. 2492, codified in relevant part at 42 U.S.C. § 1395y(b)

[2] CMS is a division of the Department of Health and Human Services, and administers the Medicare program.

[3] 42 U.S.C. § 1394, *et seq.*

[4] 1 U.S. Cong. & Admin.News, (1965) p. 1964.

million Americans.[5] Medicare's beneficiaries include persons aged sixty-five years or older; persons disabled and under aged sixty-five; and persons of all ages with permanent kidney failure treated with dialysis or transplant.

As originally written, the law provided that Medicare would be the "secondary payer" for medical treatment necessitated by employment related injuries covered by state workers' compensation laws.[6] In other words, it was intended that workers compensation insurance be the primary payer for medical treatment also covered by Medicare. Within fifteen years of enacting the law, Congress wanted to alter the secondary payer provision in order to achieve greater savings in the Medicare program.[7]

In 1980, Congress passed the Medicare Secondary Payer Act[8] and, as is evident from the House Report accompanying the legislation, Congress intended to add to the list of primary payers for medical treatment which might otherwise be covered by Medicare. The Report explains:

> Under present law, Medicare is the primary payer ... for hospital and medical services received by beneficiaries. This is true even in cases in which a beneficiary's need for services is related to an injury or illness sustained in an auto accident and the services could have been paid for by a private insurance carrier under the terms of an automobile insurance policy. As a result, Medicare has served to relieve private insurers of obligations to pay the costs of medical care in cases where there would otherwise be liability under the private insurance contract. The original concerns ... no longer justify retaining the policy. [9]

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[5] Official Website ofMedicare, www.medicare.gov.

[6] *See U.S. v. Baxter Int'l, Inc.,* 345 F.3d 866, 874-875 (11th Cir. 2003).

[7] *Id.*

[8] 42 U.S.C. § 1395y(b)(2).

[9] H.R. Rep. No. 1167, 96th Cong., 2nd Sess. 389 (1980).

The 1980 law expanded Medicare's primary payer class to include liability insurance companies, self insured companies and no fault insurance. [10] Thenceforth, Medicare would no longer pay for expenses that should be covered by these entities, since it is only secondarily liable for payment to medical providers.[11] However, in order to prevent the withholding of services or items by medical providers, Medicare usually pays first and then seeks reimbursement from the insurer once liability has been determined. [12]

To encourage compliance with these requirements, Congress added the right of subrogation and the right of direct action by the United States to recover proceeds for conditional payments.[13] Specifically, Congress authorized a private cause of action and double damages against entities designated as primary payers that fail to pay for medical costs for which they were responsible, but which are initially borne by Medicare.[14]

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[10] *See* 42 U.S.C. § 1395y(b)(2).

[11] *See* 42 U.S.C. § 1395y(b)(2)(A)(ii); 42 CFR § 411.20(a)(2).

[12] *See* 42 U.S.C. § 1395y(b)(2)(B)(i).

[13] *See Manning v. Utilities Mut. Ins. Co., Inc.,* 254 F.3d 387, 391-92 (2nd Cir. 2001).

[14] The Statute states in relevant part:
"There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement)…." 42 U.S.C. §1395y(b)(3)(A). The 1989 amendment to § 1395y(b) reorganized and consolidated the Medicare secondary payer provisions without changing the statute's wording significantly. However, the amendment's legislative history indicates that Congress intended to make explicit Medicare's right to recover conditional payments from the liability insurer or any entity paid by the liability insurer. H.R.REP. NO. 247, lOlst Cong., 1st Sess. 1021 (1989). The subsequent regulations codified at 42 C.F.R. § 411.24(g) and § 411.26 clarify the United States' subrogation right and its right to file suit against any entity receiving payment from a third party payer, in addition to the payer itself.

Through the explicit inclusion of this right, Congress intended to make it easier for the Medicare program to obtain reimbursement to which it is legally entitled. [15]

Despite enactment of the Medicare Secondary Payer statute in 1980, it was rarely followed by the insurance industry and businesses, and it was seldom enforced by the CMS.[16] Even then, CMS enforcement was restricted to certain categories ofworkers' compensation cases. For such cases, CMS issued a series of policy memoranda to be used by contractors and CMS regional offices in evaluating proposed settlements to determine whether the amount allocated for future medical expenses is reasonable.[17]

The lack of enforcement of the secondary payer provisions against entities other than workers compensation carriers resulted, primarily, from the lack of any requirement that these entities determine if a personal injury claimant was a Medicare beneficiary and then to report payments made to such a claimant. Without notice to CMS that a Medicare

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[15] H.R.Rep. No. 432, 98th Cong., 2nd Sess. 1803 (1984).

[16] T.Thomton, *Resolution of a Case with a Medicare Claimant,* For the Defense, May 2009, p. 8. Prior to 2003, the Medicare Secondary Payer law was applied so that liability insurers and self-insured companies were only responsible for compliance if they could pay promptly. In cases in which payments could not be rendered promptly, Medicare would pay. "Promptly" was defined as 120 days. *See* 42 C.F.R. § 411.50 Since liability insurers and self-insureds usually did not pay liability claims within that period, the law, apparently, did not apply. In 2003, Congress removed the word "promptly" thereby affirming that Medicare is the secondary payer in all cases in which a primary payer is available. *See* Pub. L. No. 108-173, 117 Stat. 2006, codified in scattered sections throughout 42 U.S.C. throughout§ 1395y; *see also Thompson v. Goetzmann,* 337 F.3d 489 (5th Cir. 2003); *US. v. Baxter,* 345 F.3d 866 (11th Cir. 2003).

[17] In the context of workers compensation settlements, the regulations provide that Medicare will not pay for any future medical expenses after a lump sum settlement is received until the total future medical expenses related to the employee's injury equals the amount of the lump sum settlement which was allocated to future medical expenses. 42 C.F.R. § 411.46(d)(2). Ifthe settlement agreement does not make a reasonable allocation of a portion of the lump sum to future medical expenses, Medicare can make the allocation itself according to a formula set out in the regulations. 42 C.F.R. § 411.47(a). The rationale behind this regulation regarding workers compensation carriers stems from their unique liability for the claimant's lifetime medical care. Because some part of the workers compensation settlement is set aside to pay future medical bills, CMS will deny any attempt by a workers compensation carrier to shift liability for lifetime medicals to Medicare. *See* 42 C.F.R. § 411.46(d)(2).

beneficiary received payment of a claim for which he also received Medicare benefits, it was extremely difficult for CMS to enforce its reimbursement rights under the law. That changed with the passage of the Medicare, Medicaid, and SCHIP Extension Act on December 29, 2007.

III. The Medicare, Medicaid and SCHIP Extension Act

With passage of the Medicare, Medicaid, and SCHIP Extension Act ("MMSEA"), liability insurers, no fault insurers, and self-insured companies, became legally responsible for: (1) determining whether a personal injury claimant is a Medicare beneficiary, and (2) protecting Medicare's secondary payer status by reporting payments made to such a Medicare beneficiary under a settlement, judgment or award. The new law essentially makes it easier for CMS to track secondary payer claims and enforce its reimbursement rights against insurers and self-insureds making payment to a Medicare beneficiary.

CMS defines an insurer as any entity that, in return for a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments.[18] The insurer may or may not assume the responsibility for claims processing; however, the insurer has the responsibility for the reporting requirements under the new law regardless of whether it uses another entity for claim processing.[19] CMS defines a self-insured as an entity that engages in a business, trade or profession and carries its own risk (whether by failure to obtain insurance, or

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[18] *Supporting Statement for the Medicare Secondary Payer (MSP) Mandatory Insurer Reporting Requirements of Section 111 of the Medicare Medicaid, and SCHIPP Extension Act of 2007 (P.L. 1101173),* (CMS-10265), Attachment A – Definitions and Reporting Responsibilities.

[19] *Jd; see* 42 U.S.C. § 1395y(b)(8)

othetwise) in whole or in part.[20] Self-insurance can be demonstrated by a settlement, judgment, award, or other payment to satisfy an alleged claim (including any deductible or co-pay) for a business, trade or profession.[21] These insurers and self-insureds are referred to individually as a "Responsible Reporting Entity."[22]

Each Responsible Reporting Entity ("RRE") must have registered electronically with CMS before September 30, 2009.[23] RREs may register to submit reports themselves, or they may register a designated agent to submit reports on their behalf. Registered RREs began submitting reports on claims as of July 1, 2009, as part of a test submission to confirm that the RREs are able to provide files including all required information in the format and according to the schedule defined my CMS. However, the testing period expires on December 31, 2009, and all RREs must be in compliance with MMSEA reporting requirements beginning January 1, 2010.[24]

A. Responsibility to Determine Medicare Beneficiary Status

MMSEA places the obligation on the primary payer (i.e., the insurers and self-insureds) to determine whether the claimant is *"entitled to benefits* under the [Medicare] prograrn."[25] While most commentators have suggested that the law requires the RRE to

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[20] *!d.*

[21] *!d.; see also* 42 C.F.R. § 411.50.

[22] MMSEA Section 111 Medicare Secondary Payer Mandatory User Guide, available at http://www.cms.hhs.gov/MandatoryfusRep.Downloads/NGHPUserGuide031609.pdf (March 16, 2009 User Guide).

[23] CMS Revised Implementation Timeline (20090512) dated May 12,2009.

[24] *!d.*

[25] 42 U.S.C. § 1395y(b)(8)(A)(i) *(emphasis added).*

ascertain simply whether a claimant has, or is currently, receiving Medicare benefits at the time of payment, a strict construction of the statute suggests otherwise. The text can be interpreted as requiring the RRE to determine whether a claimant, although not currently receiving Medicare benefits, *is entitled* to them and, therefore, may receive them in the future. In such a case, a settlement may have to undergo an analysis similar to that required in a workers' compensation settlement.[26]

CMS has established an electronic database by which RREs, in possession of a claimant's social security number or Medicare Health Insurance Claim Number ("HICN"), can query CMS regarding that claimant's Medicare beneficiary status. The social security number is used as the basis of the HICN. CMS uses the HICN to identify Medicare beneficiaries receiving health care services and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. Absent the claimant's social security number or HICN, CMS would not be able to systematically link the reported data to a particular Medicare beneficiary.

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[26] *See* footnote 17, *supra.* By way of illustration, suppose a 60 year old Jones Act seaman with little formal education (who has not, and currently is not, receiving Medicare benefits) desires to settle a claim for a debilitating injury that precludes him from returning to work as a seaman. Given his age and educational history, he likely will not be employable in the future, and his claim consists of future lost wages, pain and suffering, and medical treatment, including future care. Prior to MMSEA, it would not be unusual for the defendant/insurer to settle with the claimant in exchange for a full and fmal release of all claims and damages of any sort arising from the injury, including future medical care; the claimant would receive a lump sum and the two parties go their separate ways. However, considering that the claimant's current disability may *entitle* him to Medicare benefits, what happens a year later after the claimant has spent the settlement funds and obtains Medicare benefits related to the disability? Can Medicare seek reimbursement from the RRE even though the claimant was not a Medicare beneficiary on the date of the settlement payment, but was *entitled* to receive Medicare as a result of his disabling injury? Is the RRE required to determine whether it is reasonably foreseeable that a claimant who is *entitled* to Medicare benefits, but not actually receiving them, will begin to receive them at some future date as a result of the injury? Inevitably, these questions will be addressed by the federal courts as the new law works its way through the judicial system.

After the RRE submits a query, including the claimant's name, date ofbirth, gender, and social security number, CMS will respond to the query using the information provided by the RRE. If there is a match (i.e., the claimant is or was previously receiving Medicare benefits), then CMS will send back the HICN for that claimant, and the RRE is on notice of its legal obligation to report any payment made in settlement or satisfaction of the claim, and to protect Medicare's right to reimbursement.

lfthe CMS database discovers no match with the information provided, then the RRE, still, is not relieved of its obligation to later report a payment if the claimant is, in fact, a Medicare beneficiary. The RRE is, essentially, strictly liable for determining a claimant's Medicare beneficiary status. There is no "safe harbor" or good faith exception to the requirements of Section 1395y(b)(8)(A)(i). In other words, if the claimant provides an incorrect social security number which the RRE uses to query his status as a Medicare beneficiary, the RRE cannot rely on the information provided by CMS so as to immunize itself from liability in a subsequent enforcement action.[27]

B. Responsibility to Report Payment of Personal Injury Claim to a Medicare Beneficiary

Once an RRE determines that a personal injury claimant is "entitled to benefits under the [Medicare] program,"[28] the RRE *shall* report electronically to CMS any payment to the claimant after July 1, 2009, via settlement, judgment or otherwise.[29] It is irrelevant to CMS whether there has been an admission or finding of liability. The

[27] CMS Office of Financial Management, Compliance Guidance Regarding Obtaining fudividual HICNs and/or SSNs for Reporting, May 26, 2009.

[28] 42 U.S.C. § 1395y(b)(8)(A)(i).

[29] 42 U.S.C. § 1395y(b)(8)(A)(ii). Presumably this would include maintenance and cure payments made to an injured seaman entitled to benefits under the Medicare program.

reporting process becomes mandatory for all RREs on January 1, 2010. These electronic reports are sent by the RRE on a quarterly basis and must include numerous data elements required by CMS, such as:

- the claimant's name, address, date ofbirth, gender, and SSN/HICN
- the name and address of the insurer and insurance policy number
- the name and address of the policy holder and any additional insureds
- the name and address of claimant's attorney
- the date ofthe injury, nature ofthe injury, and cause of injury
- the jurisdiction where the injury occurred
- the date ofthe settlement, judgment, award or other payment
- the amount of payment, and the resolution ofthe claim (i.e., contested and resolved with no ongoing responsibility; contested and resolved with ongoing responsibility; uncontested with ongoing responsibility; or uncontested with no ongoing responsibility).[30]

Armed with this information, CMS will undoubtedly have an easier time enforcing its legal right to reimbursement, thereby fulfilling the legislative intent of MMSEA. The penalties and damages for non-compliance with the secondary payer provisions ofMMSEA can be significant for those entities who would attempt to circumvent the new regulations.[31]

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[30] The amount of any attorney's fees or other procurement costs borne by the Medicare beneficiary and associated with the settlement, judgment or award should also be considered by Medicare in order to properly calculate the amount of the reimbursement claim and issue a reimbursement demand letter. *See* 42 C.F.R. § 411.37.

[31] When repaying conditional payments without enforcement action by the United States, the amount recoverable by CMS is the lesser of either the Medicare conditional payment, or the amount of the full primary payment that the primary payer is obligated to pay. *See* 42 C.F.R. § 411.24(c).

IV. Enforcement and Penalties for Non-Compliance

Since 1980, the United States has had the legal right of subrogation and direct action to enforce its entitlement to reimbursement of Medicare benefits in secondary payer situations.[32] However, without notice that a Medicare beneficiary was pursuing a tort remedy against a third party, it was difficult for the United States to enforce its right of reimbursement. Now that the burden is on the insurers to determine Medicare beneficiary status and report payments in satisfaction of personal injury claims, the United States' ability to enforce its reimbursement rights is substantially enhanced.[33]

In the event that the Medicare program is not reimbursed for its conditional payments made on behalf of its beneficiary, the law provides numerous avenues of recovery available to the United States.[34] First, the United States may recover its conditional payments "by direct collection or by offset against any monies [it] owes the entity responsible for refunding the conditional payment."[35] Second, the United States has a direct right of action "against any or all entities that are or were required or responsible ... to make payment with respect to the same item or service ... under [an insurance policy or self-insured plan]," including collection of double damages.[36] If the recipient of the payment from the primary payer fails to reimburse Medicare within sixty

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[32] 42 U.S.C. § 1395y(b)(3); *see Zinman v. Shalala,* 67 F.3d 841, 845 (9th Cir. 1995).

[33] U.S. Attorney's Offices in some federal districts have begun to partner with local hospitals to log all medical records requests via subpoena or otherwise. Comments of R.Trusiak, Assistant U.S. Attorney for the Western District of New York, during CLE seminar entitled The Medicare Secondary Payer Statute and the Medicare Medicaid and SCHIP Extension Act: Impact on Litigating Personal lnjurv Claims, August 26, 2009.

[34] R.Trusiak, *The Medicare Secondary Payer Statute,* N.Y.St.B.J., January 2009.

[35] 42 C.F.R. § 411.24(d).

[36] 42 U.S.C. § 1395y(b)(2)(B)(iii); 42 C.F.R. § 411.24(c)(2) and (e).

days, then the primary payer "must reimburse Medicare even though it has already reimbursed the beneficiary or other party."[37] Third, the United States may bring a direct action against "any entity that has received a payment from an [insurer or self-insured] or from the proceeds of[an insurer or self-insured] to any entity."[38] The Medicare regulations provide that CMS has a right of action to recover its payments from *any* entity that has received a primary payment and explicitly includes "a beneficiary, provider, supplier, physician, *attorney,* State agency or private insurer."[39]

Congress also provided the United States with a separate subrogation right.[40] "The United States shall be subrogated … to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan."[41] This is sometimes referred to erroneously as a Medicare *lien.* Medicare

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[37] *Health Ins. Ass'n Of Am, Inc. v. Shalala,* 23 F.3d 412,417 (D.C. Cir. 1994); 42 CFR § 411.24(i)(1). Under such a scenario the primary payer (i.e., insurer or self-insured) could end up paying three times the amount of Medicare's original reimbursement right (once to the claimant and as double damages to the United States).

[38] 42 U.S.C. § 1395y(b)(2)(B)(iii); *see Hadden v. United States,* 2009 WL 2423114 (W.D. Ky. 2009).

[39] R.Trusiak, *The Medicare Secondary Payer Statute,* N.Y.St.B.J., January 2009, *citing* 42 C.F.R. § 411.24(g).

[40] *Id.*

[41] 42 U.S.C. § 1395y(b)(2)(B)(iv); *see also* 42 U.S.C. § 411.26(a). The Medicare regulations also empower Medicare to "join or intervene in any action related to the events that gave rise to the need for services for which Medicare is paid." 42 C.F.R. § 411.26(b). Since most of the underlying tort litigation takes place in state courts and since such courts lack jurisdiction over the Medicare program, CMS does not normally intervene in such actions. R.Trusiak, *The Medicare Secondary Payer Statute,* N.Y.St.B.J., January 2009, *citing Hoste v. Shanty Creek Mgmt., Inc.,* 246 F.Supp.2d 784, 788-89 (W.D. Mich. 2002) and *Mitchell v. Health Care Serv. Corp.,* 633 F.Supp. 948, 949 (N.D. TIL 1986).

does not have a *lien* on the proceeds of payment, or *res,* but a right as a claimant to recover from entities that have a primary obligation to pay under the statute.[42]

Aside from the aforementioned damages, MMSEA added a provision for a monetary fine of$1,000 per day for *each individual claimant* that the RRE fails to report as a Medicare beneficiary receiving payment via settlement, judgment or otherwise as of July 1, 2009.[43] As explained previously,[44] there is no safe harbor or good faith provision under MMSEA regarding the RRE's compliance with the reporting requirements. If a claimant provides the wrong social security number, or the RRE otherwise supplies erroneous information to CMS that results in a determination that the claimant is not a Medicare beneficiary, the RRE still is liable for reporting and reimbursement if it later turns out that the claimant is a Medicare beneficiary.

The proper statute of limitations applicable in cases involving insurers and self-insureds who fail to reimburse Medicare is six years.[45] The courts have held that the six year limitations period is applicable to these secondary payer claims by virtue of 28 U.S.C. § 2415(a), which provides that actions for money damages brought by the United States are barred unless filed within six years after the right of action accrues. "In

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[42] *See Zinman v. Shalala,* 835 F.Supp. 1163, 1171 (N.D. Cal. 1993), *aff'd,* 67 F.3d 841 (9th Cir. 1995). The courts have recognized that Medicare's right to reimbursement is paramount to any other claim. *See US. v. Geier,* 816 F.Supp. 1332, 1337 (W.D. Wis. 1993).

[43] 42 U.S.C. § 1395y(b)(8)(E)(i).

[44] Footnote 27, *supra.*

[45] *See Manning v. Utilities Mut. Ins. Co., Inc.,* 254 F.3d 387, 397-98 (2nd Cir. 2001).

liability and no-fault cases, the right of action accrues from the *later* of the date of payment or the date that Medicare learns of the payment."[46]

V. Personal Injury Practice in a Post-MMSEA World

The federal bureaucracy has never enjoyed a reputation for speed and, therefore, practitioners desiring to settle personal injury cases would do well to determine Medicare beneficiary status at an early stage in the litigation process. Discovery of the issue should be accomplished promptly in order to ascertain whether a claimant is "entitled to benefits under the [Medicare] program," and whether Medicare has advanced funds as a secondary payer. It is emphasized that Medicare is not required to place any of the parties on notice of its interest in any settlement. Rather the law requires the settling parties to determine if Medicare has any interest in a settlement being made with a Medicare beneficiary and, if so, the extent ofthat interest. The amount ofMedicare's reimbursement right will be critical to meaningful settlement negotiations.[47]

Even if the parties are able to reach a settlement agreement, it is questionable whether distribution of the proceeds will occur before CMS issues its reimbursement demand letter, because the RRE will be reluctant to distribute the settlement funds without adequate assurances that it will not have to pay again.[48] If Medicare has advanced medical costs as a secondary payer, and an insurer or self-insured desires to protect itself from a reimbursement action by the United States, it may consider issuing

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[46] R.Trusiak, *The Medicare Secondary Payer Statute,* N.Y.St.B.J., January 2009, *(emphasis in original).*

[47] Such considerations are not unlike third party tort actions involving a workers' compensation carriers' lien.

[48] Medicare estimates 30-60 days response time from being notified of the terms of a proposed settlement.

the settlement funds as a two party check payable to CMS and the Medicare beneficiary or his attorney. The settlement or judgment funds could also be interplead into federal court with notice to CMS, although such an action appears unlikely as part of a settlement agreement. Further, still, the RRE can simply withhold the funds until CMS has properly responded with its demand and then pay CMS reimbursement costs directly.

Because the RRE reports to CMS on a quarterly basis, it is conceivable that a settlement agreement reached in the early part of the quarter will not be reported for two or three months, after which another two or three months could elapse until the RRE receives a demand letter from CMS.[49] The RRE should also have protocols in place to ensure that, for those personal injury claims settled after they are reported, the claimant has not since become a Medicare recipient at the time of payment of any kind. Ultimately, such considerations substantiate the importance of determining Medicare beneficiary status at an early stage of the litigation.

Some commentators have suggested that, through artful pleading, a Medicare beneficiary could avoid the issue by not seeking medical costs as part of his claim. However, considering that a standard personal injury Release usually includes all damages and injuries of any kind arising from the incident sued upon, it is doubtful whether a defendant would agree to specifically exclude from a release any liability for medical costs, past, present, or future. In any event, if the settlement agreement provides that the payment is limited to lost income or other non-medical expenses, the payment

[49] The obligation for electronically reporting the settlement rests entirely with the RRE and cannot be delegated or transferred to the claimant or his attorney.

must still be reported since CMS is not bound by allocation of medical expenses by the parties.[50]

VI. Conclusion

For legal practitioners in the workers compensation arena, the requirements with respect to Medicare's secondary payer and reimbursement status are nothing new. However, MMSEA could provide a trap to those legal practitioners in the tort liability arena, including Jones Act, passenger, and other personal injury claims, who are unfamiliar with its reporting, penalty, and enforcement provisions. Given the legal ramifications to the claimant, his attorney, the insurer, self-insured, and their attorneys, it is in the interests of all to identify Medicare beneficiary issues during the early stages of the litigation process, in order to properly evaluate likely settlement scenarios and to protect Medicare's legal right to reimbursement.

[50] R.Trusiak, *The Medicare Secondary Payer Statute*, N.Y.St.B.J., January 2009.