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## **Medicare Pitfalls When Settling Personal Injury Actions: What the Trucking Industry Needs to Know**

It should come as no surprise, especially in the current economic climate, that government, whether federal, state or local, is exploring various avenues to replenish its coffers. The Medicare, Medicaid and SCHIP (State Children's Health Insurance Program) Extension Act (MMSEA), which will take effect on July 1, 2009 for primary payers, mandates that liability insurers, self-insured entities and no-fault carriers, among others, ascertain if a plaintiff is entitled to Medicare benefits and, if so, report any settlement to the Department of Health and Human Services. U.S.C.A. § 1395y(b)(8). The objective is for the federal government to receive reimbursement for Medicare expenses incurred or to be incurred for an injury sustained due to other parties' tortious conduct.

Beginning in 1980, Congress enacted amendments to the Social Security Act known as the Medicare Secondary Payer Act (MSP) in an effort to curb Medicare's costs. 42 U.S.C.A. § 1395y(b). This statute's objective is to obtain payment for medical treatment that Medicare would otherwise be obligated to pay, from some other entity, whether it be a group health insurance plan, a no-fault insurer or a liability insurer. The statute addresses the responsibility of entities to make payment in the first instance to a beneficiary as well as entities' responsibility to reimburse Medicare when Medicare has already made a payment on behalf of a beneficiary. 42 U.S.C.A. § 1395y(b)(2).

Also related is the Medical Care Recovery Act (MCRA), which permits the federal government to bring an action against a third person who has tort liability for the injuries sustained by a person who has received, or will be entitled to receive, medical treatment which is or must be paid by the federal government, i.e., Medicare payments. 42 U.S.C.A. §§ 2651-53.

There are three aspects to these statutes which must concern every liability insurer or those companies that are self-insured when settling a claim or personal injury

action. First, Medicare's prior payments. Second, Medicare's future interests. Last, the new reporting requirements for liability insurers and self-insured entities, among others. Failure to address any of these issues may come with a steep price tag.

### **I. Medicare's Lien**

Medicare has authority to make conditional payments to beneficiaries if a "primary plan", defined in the statute as including a liability insurance policy (including a self-insured plan), "has not made or cannot reasonably be expected to make payment promptly." 42 U.S.C.A. § 1395y(b)(2)(B)(i) and (ii). For instance, where a person makes a claim against someone who is insured or self-insured and it is a controverted claim, prompt payment for medical treatment may not be agreed upon. 42 U.S.C.A. § 1395y(b)(2)(B)(i). When Medicare makes such conditional payments, the statute allows the federal government to recover double damages against any or all entities that are or were required to be responsible for such a payment, including an insurer or self-insurer. 42 U.S.C.A. § 1395y(b)(2)(B)(iii) and 42 C.F.R. 411.24(c)(2).

If Medicare has paid for any of a plaintiff's medical treatment which is related to the injury involved in a claim, when the claim is settled or a recovery is received, Medicare must be reimbursed. The Secretary of Health and Human Services bears the burden of demonstrating that the treatment was related to the injury which was the subject of the litigation. *Estate of Urso v. Thompson*, 309 F.Supp.2d 253 (D.Conn. 2004). Medicare is entitled to reimbursement even though the claim settles without any recognition of liability by the defendant or the party against whom the claim was asserted. 42 U.S.C.A. § 1395y(b)(2)(B)(ii). Medicare can seek reimbursement from the beneficiary, his or her attorney if they received a fee, a provider, or the liability insurer or self-insured. 42 C.F.R. 411.22. Moreover, Medicare can seek reimbursement from the liability insurer or self-insurer, even though it has already made payment to the beneficiary or any other entity for the treatment. 42 C.F.R. 411.24(i). The Medicare Secondary Payer Recovery Contractor (MSPRC), implemented in October of 2006, administers MSP recovery efforts.

### **II. Medicare Set Aside Trusts**

In addition to recovering past payments, the current trend is to ensure that plaintiffs and insurers are not shifting responsibility for future medical treatment to the federal government. Under the MCRA, the federal government is entitled to bring an action against a tortfeasor for the reasonable value of medical treatment furnished or to be furnished. 42 U.S.C.A. 2651. This language seems to include an action by the federal government against a tortfeasor for the value of future medical treatment that it would otherwise be obligated to pay.

A question that arises upon the settlement of a personal liability claim when the claimant is receiving Medicare or may become entitled to Medicare in the near future is: Should a portion of the settlement be "set aside" to cover payment for future treatment that Medicare would otherwise be obligated to pay?

In the Workers' Compensation arena, there are already regulations in effect that address establishing a Medicare Set Aside Trust, and one could reasonably expect that the government will soon propose new regulations imposing similar requirements on no-fault, liability insurers and self-insurers when settling personal injury actions.

If a Workers' Compensation settlement intends to compensate the individual for all future medical treatment, the claimant must expend the entire settlement on medical expenses that would otherwise be covered by Medicare before he or she is entitled to receive benefits again. 42 C.F.R. 411.46(a). If the agreement appears to attempt to shift the responsibility for medical treatment for a work-related injury to Medicare, Medicare will not recognize the agreement or pay for treatment related to the work-related injury. 42 C.F.R. 411.46(b)(2). Finally, if a portion of the agreement is allocated to medical expenses, Medicare will not pay for those services until they equal the amount allocated to those expenses in the lump sum agreement. 42 C.F.R. 411.46(d)(2).

The Center for Medicare and Medicaid Services' (CMS) guidelines provide for the review of Workers' Compensation lump sum agreements for approval when: (1) the amount of the settlement is greater than \$25,000.00 and the injured worker is entitled to Medicare at the time of the settlement, or (2) the injured worker has a "reasonable expectation" of becoming eligible for Medicare within 30 months of the settlement and the settlement exceeds \$250,000.00. See [www.cms.hhs.gov](http://www.cms.hhs.gov). The fact that these are mandatory guidelines for submission to CMS does not relieve practitioners and parties from compliance with the statute and regulations, but only defines those agreements that CMS will review and approve or disapprove.

While currently the regulations only address Workers' Compensation settlements, it is difficult to see how there is a difference in Medicare's interests in a liability action if a plaintiff is entitled to Medicare at the time a recovery is received or has a reasonable expectation of becoming entitled to Medicare soon thereafter. Thus, cautious practitioners should seek CMS approval and/or establish Medicare Set Aside Trusts in connection with settlement of liability actions where the plaintiff is entitled to Medicare or will be shortly.

### **III. Reporting Requirements For Liability Insurance Carriers and Self-Insureds**

As previously noted the MMSEA, which takes effect on July 1, 2009, mandates reporting requirements for liability insurers, self-insured entities, no-fault insurance and Workers' Compensation insurers. 42 U.S.C.A. § 1395y(b)(8). The statute requires every liability insurer and self-insured to ascertain whether a plaintiff, including those with claims that are unresolved, is entitled to Medicare benefits. 42 U.S.C.A. § 1395y(b)(8)(A)(i). In the event a plaintiff is entitled to benefits, the liability insurer or self-insured must notify the "Secretary" (of the Department of Health and Human Services) (HHS) after the claim is resolved, regardless of whether there is a determination of liability. 42 U.S.C.A. § 1395y(b)(8)(C). Thus, the secretary must be notified if a settlement is reached. Most importantly, a failure to comply with the reporting requirements can result in a \$1,000.00 per day per claimant civil penalty. U.S.C.A. § 1395y(b)(8)(E)(i).

HHS and CMS have information on their website to guide “Responsible Reporting Entities” (RREs) on how to comply with the reporting requirements. See [www.cms.hhs.gov/mandatoryinsrep/](http://www.cms.hhs.gov/mandatoryinsrep/). How the mandatory reporting requirements are going to be implemented is a work in progress for the HHS and CMS, and recently a new timetable for testing an RRE's implementation of the reporting requirement was announced.

See [http://www.cms.hhs.gov/MandatoryInsRep/Downloads/Alert\\_UserGuideSuppNGHP.pdf](http://www.cms.hhs.gov/MandatoryInsRep/Downloads/Alert_UserGuideSuppNGHP.pdf) and <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUser-Guide031609.pdf>. RREs must proactively seek information about compliance as the procedure evolves. What has been decided is that the reporting will be done electronically and thus insurers and self-insureds must register with CMS so that a procedure will be in place when the statute takes effect.

The statutes imposing these requirements, the regulations implementing their application, and the agency guidelines suggesting appropriate procedures for compliance present a quagmire for those striving to comply with the law. As the effective date moves closer, it is imperative that insurance carriers and self-insured entities take the time to review the statute's mandates to ensure they are in compliance when settling personal injury matters.

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