AMERICAN BAR ASSOCIATION
YOUNG LAWYERS DIVISION

LITIGATION COMMITTEE

RECOMMENDATION AND REPORT TO THE ASSEMBLY OF THE YOUNG LAWYERS DIVISION

RECOMMENDATION

RESOLVED, that the American Bar Association urges Congress to amend the Medicare, Medicaid and SCHIP Extension Act of 2007 to create a safe harbor provision protecting responsible reporting entities from civil penalties when they rely on claimants' verified representations regarding claimants' entitlement to or receipt of Medicare benefits.

REPORT

On December 29, 2007, former President George W. Bush signed into law the Medicare, Medicaid and SCHIP Extension Act of 2007 (the "Act"), which adds certain reporting requirements to the Medicare Secondary Payer Act (the "MSP").[1] The purpose of the Act is to protect Medicare's interest in settlements, judgments, awards, or other payments involving claimants who are Medicare recipients. Practically, however, the Act could delay or impede settlements as well as result in unjust monetary sanctions against insurers, third-party administrations, and/or their agents who are attempting to resolve the claims.

Beginning January 1, 2010, Section 111 of the Act requires responsible reporting entities ("RREs") that pay a settlement, judgment or award to a Medicare beneficiary to report certain information about that claim to the Secretary of Health and Human Services (the "Secretary").[2] The failure to report this information to the Secretary could result in a fine of $1,000 each day the RRE is not in compliance.[3]

A responsible reporting entity ("RRE") is an entity that funds and pays, in whole or in part, a settlement, judgment, award or other payment to a Medicare beneficiary. Thus, the RRE designation would encompass insurers, whether they be liability insurers, no-fault insurers, or workers' compensation insurers, as well as self-insurers and third-party administrators.

According to the Act,

> (8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS-
>
> (A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall--
>
> (i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and
>
> (ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.
>
> (B) REQUIRED INFORMATION- The information described in this subparagraph is--

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[1] *See* 42 U.S.C. §1395y(b)(8).
[2] 42 U.S.C. § 1395y(b)(8)(A).
[3] 42 U.S.C. §1395y(b)(8)(E).

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

(C) TIMING- Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) CLAIMANT- For purposes of subparagraph (A), the term 'claimant' includes--

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) ENFORCEMENT-

(i) IN GENERAL- An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) APPLICABLE PLAN- In this paragraph, the term `applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

> (G) SHARING OF INFORMATION- The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.
> (H) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise. [4]

One of the pitfalls with respect to these reporting requirements is that there is no safe harbor provision allowing the settling RRE to rely on representations made by a claimant in determining whether the claimant is entitled to or has received Medicare benefits. In other words, if the claimant falsely states that he/she is not entitled to and/or has not received Medicare benefits, and the RRE, in reliance thereon, does not report the settlement, the RRE may still be fined for not complying with the reporting requirements.

There is no parallel exposure to a Medicare claimant who does not report payments received from an RRE. Under the Act, the obligation to identify Medicare beneficiaries and the monetary fine for failure to identify and report payments made to Medicare beneficiaries rests solely with the RRE. This is true even though the claimant, rather than the RRE, is often in a better position to comply with the reporting requirements. This Recommendation intends to address this inequality in the Act through a safe harbor provision which protects an RRE from a monetary fine where the RRE reasonably relies on verified information provided to the RRE by a claimant(s) regarding the claimant(s) status as a Medicare beneficiary.

Respectfully submitted,

ABA YLD Litigation Committee
December 2009

[4] 42 U.S.C. §1395y(b)(8).

ABA/YLD RECOMMENDATION
GENERAL INFORMATION FORM

Submitting Entity: ABA YLD Litigation Committee

Submitted By: Hope T. Cannon, Vice-Chair
ABA YLD Litigation Committee

1. Summary of Recommendations:

   The ABA supports a legislative amendment to the Medicare, Medicaid and SCHIP Extension Act of 2007 (the "Act"), to add a safe harbor provision protecting responsible reporting entities from civil penalties for relying on verified representations made by claimants regarding their eligibility for or receipt of Medicare benefits.

2. Date of Approval by Submitting Entity:

   Approved December 4, 2009, by the Leadership of the ABA YLD Litigation Committee.

3. Has this or a similar recommendation been submitted to the Assembly or ABA previously?

   Not to our knowledge.

4. Are there any Division or ABA policies that are relevant to this recommendation and, if so, would they be affected by its adoption?

   Not to our knowledge.

5. Does this recommendation require immediate action at the next Assembly? If so, why?

   Yes, because the reporting requirements imposed by the Act begin on January 1, 2010.

6. Status of Legislation (if applicable)

The Medicare, Medicaid and SCHIP Extension Act of 2007 was signed into law on December 29, 2007. However, the reporting requirement does not begin until January 1, 2010.

7. Cost to the Association

   None.

8. Disclosure of Conflict of Interest

None.

9. Referrals

None.

10. Contact People (who will present the report to the executive council and/or assembly)

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