MEDICARE INTERESTS IN LIABILITY ACTIONS

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There has been a lot of confusion and discussion in recent months regarding the issue of Medicare compliance in liability cases. Specifically, the question among parties to any lawsuit where a payment for medical services has been made by Medicare seems to be: "What is the responsibility of parties to a liability action to report to the Center for Medicare/Medicaid Services, or "CMS", a settlement or judgment under the Medicare Secondary Payer Statute (MSP)?" This is really a three-pronged question. The basic issues this article will discuss are as follows:

1. What are the current obligations of liability primary payers under the MSP?

2. What impact do the requirements of Senate Bill 2499, Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), (Public Law 110-173) have on liability primary payers?

3. Are liability primary payers obligated to account for "future interests" of Medicare by providing Medicare Set Aside (MSA) arrangements in settlement discussions?

I. Background

First, a bit of background. The Medicare Secondary Payer Statute, otherwise known as the "MSP," states, quite simply, that any payment made by the Center for Medicare/Medicaid Services ("CMS") on behalf of a Medicare beneficiary for medical services is supplemental (or secondary) to any other potential source of payment for those medical services. For example, if a Medicare recipient is covered by both a commercial health insurance plan and Medicare, the health insurance plan is to be billed first. Once reimbursement is received from the commercial plan, then Medicare can be billed for any further reimbursement to which the health care provider may be entitled.

This same procedure of billing CMS after other potential sources of payment have been exhausted is followed when a primary payment may be owed by a liability insurer due to, for example, an auto accident, a claim of medical malpractice, a slip-and-fall injury, etc. However, due to the length of time it may take to make and perfect a claim that some other entity (i.e., a liability insurance carrier) is responsible for payment for the Medicare recipient's injuries, CMS will make a "conditional payment" for services covered by Medicare to the health care provider so that they do not get left "holding the bag" for services rendered.

As discussed more fully below, Senate Bill 2499, entitled "Medicare, Medicaid, and SCHIP Extension Act of 2007" or "MMSEA" for short, which took effect July 1, 2009, is an amendment to the MSP which is intended to protect CMS's interest in conditional payments.

II. Current Obligations of Liability Primary Payers under the MSP

Under the current version of the MSP, primary payers already have obligations to CMS when it comes to making payments to a Medicare beneficiary. But first, let's discuss who is affected by the MSP statute.

What is a Primary Payer or Plan?

Under the MSP, the definition of a **"primary plan"** includes an automobile or liability insurance policy or plan (including a self-insured plan) or no-fault insurance.... An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.[1] Several forms of insurance fit in the category of "liability insurance," including, but not limited to, automobile, self-insurance, uninsured motorist, under-insured motorist, homeowners, malpractice, product liability, general liability, medical payments coverage, medical expense coverage and no-fault.[2]

How do Medicare "Conditional Payments" Affect a Primary Plan?

A **"conditional payment"** under the MSP can be defined as a payment made by Medicare for services for which another payer is responsible.[3] Conditional payments can arise in a multitude of ways. In liability matters, they typically arise from the fact that most claims of liability are denied. When a claim is denied, then the primary payer typically does not pay the medical expenses or services for the accident-related injuries of the injured party. Typically, then, if the injured party is a Medicare beneficiary, Medicare will end up providing and paying for the injured party's medical treatment.

In general, under the current MSP "conditional payment" rule, payment will not be made by Medicare if "payment has been made, or can reasonably be expected to be made, under a workers' compensation law or plan..., or under an automobile or **liability insurance policy** or plan (including a self-insured plan) or under no fault insurance."[4] However, Medicare may make a "conditional payment" if a primary plan has not made or cannot reasonably be expected to make payment with respect to an item or service promptly (as determined in accordance with regulations). Any such payment...shall be conditioned on reimbursement to the appropriate Trust Fund.[5]

Under 42 U.S.C. § 1395y(b)(2)(B)(ii), a primary plan, *and* an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by Medicare, if it is demonstrated that the primary plan has or had a responsibility to make payment with respect to the item or service. A primary plan's responsibility for a payment may be demonstrated by a judgment, a payment conditioned upon the recipient's

compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.[6] A settlement or contractual obligation is also considered evidence of a primary plan's "responsibility" to make payment under the MSP.[7]

Medicare has broad enforcement powers under the MSP for collecting repayment. Medicare has a direct right against all primary payers responsible for making payment.[8] Medicare also has a direct right against any entity that received a primary payment, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer.[9] CMS does not even need to take legal action to be entitled to a recoverable amount. However, if they do need to take legal action, the consequences can be dire.

If CMS is not required to take legal action, then the amount of the repayment of conditional payments is the lesser of either the Medicare primary payment, or the amount of the full primary payment that the primary payer is obligated to pay.[10] If it is necessary for CMS to take legal action, Medicare may recover twice the amount of the Medicare primary payment.[11] CMS also has a subrogation right and the rights of joinder and intervention.[12]

Additionally, CMS requires that the payment be made promptly. Under the MSP, reimbursement must be made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for the payment or other information is received.[13] If payment is not made within the 60-day period, Medicare may charge interest on the amount of the reimbursement beginning with the date on which the notice or other information is received until reimbursement is made (at a rate determined by Medicare in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).[14]

What Are the Notice Requirements?

Primary payers are also required to place Medicare on notice of claims implicating its interests.[15] Under that provision, primary payers are obligated to place Medicare on notice "if it is demonstrated to a primary payer that CMS has made a Medicare primary payment for services for which the primary payer had made or should have made primary payment...."[16]

III. Senate Bill 2499 Impact

Senate Bill 2499, which is an amendment to the MSP, became effective on July 1, 2009 for all primary payers except group health plans, for which the effective date was January 1,

2009.[17] The purpose of the amendment is to protect Medicare's interests for conditional payments. Senate Bill 2499 significantly impacts the current obligations of all primary payers.

Senate Bill 2499 places an affirmative obligation on all primary payers to (a) determine if a claimant is entitled to Medicare and (b) notify Medicare of said entitlement as specifically required.[18] MMSEA, Section 111(a)(8)(A)(i) states primary payers must "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, under MMSEA, Section 111(a)(8)(A)(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.

Subparagraph (B) of Section 111(a)(8) requires the following information be submitted to CMS: the identity of a Medicare beneficiary whose illness, injury, incident, or accident was at issue as well as such other information specified by the Secretary to enable an appropriate determination concerning coordination of benefits, including any applicable recovery claim.[19] It is important to note that it is not yet clear as to what other information, other than the beneficiary's identity, will be required by CMS.

The timing of the report is governed by subparagraph (C) of Section 111(a)(8), which states that the information shall be submitted 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).[20] According to the CMS website, last updated on July 27, 2009, the time for reporting has not yet been specified by the Secretary. The website does state, however, that submissions will be required to be in an electronic format.

The penalty for non-compliance with the requirements with respect to any claimant is $1,000.00 for each day of noncompliance with respect to each claimant. This civil money penalty is 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.[21]

IV. Medicare Set Aside (MSA) Arrangements in Liability Cases

In general, a Medicare Set Aside, or MSA, is defined as a CMS recommended method to protect Medicare's future interests in a case through which the parties to a settlement allocate or "set aside" a sum of money from that settlement to cover future anticipated medical expenses for a claimant's accident related injuries that would otherwise be covered under Medicare.[22] MSAs have been required in the workers' compensation for certain settlements since 2001. 42 C.F.R. § 411.46.

However, with the passage of MMSEA Senate Bill 2499, the question that has been raised is, "are MSAs applicable in liability cases?" The short answer to that question is "no." MSAs are currently not required by the MSP in liability cases. The language of the MSP, CMS policy memoranda and alerts on the subject have supported that premise, as well.[23]

However, that is not the end of the story. First, CMS could use MMSEA Senate Bill 2499 as a step toward further Congressional amendments with specific provisions for MSAs, or, at least, a clarification of whether MSAs are required in liability cases. Moreover, with the current push toward compliance with the MSP and CMS's effort to reduce expenditures in general, one might reasonably expect that MSAs may be required in the future in liability cases.

In 2005, three CMS staff members verified CMS's position on future medicals. They stated:

> "CMS has advised that it is not asking for Medicare Set-Aside arrangements, nor does it have any current plans for a formal process for reviewing and approving Medicare Set-Aside arrangements, in liability cases.
>
> However, even though no formal process exists, there is an obligation to inform CMS when past or future medical expenses were a consideration in reaching the liability settlement, judgment, or award whether or not specifically provided for in the settlement, judgment, or award in cases involving a Medicare beneficiary.
>
> In addition, CMS' expects that any settlement funds that were intended to compensate for future medicals be spent for that purpose before any claims related to the settlement, judgment or award are submitted to Medicare for payment."[24]

Indeed, even though there is no formal review process in place, CMS has agreed to review liability MSA submissions, in certain settlements in liability cases. Additionally, it appears, by the CMS staffers' own words and by the actions taken by CMS to review MSA submissions, that the actions of CMS indicate that they expect their future interests to be protected (at least somewhat). Therefore, even though there is no actual "requirement" for a MSA in a liability case, we still may want to plan for Medicare's future interests when settling cases. This, of course, may be client-specific, depending on their level of comfort with the MSP.

Now What Do We Do?

At this point, it is really up to the primary payer (i.e. the insurance company) how to handle future medical as part of settlement, if they choose to consider future medical expenses at all. If it is decided that future medicals are going to be considered, then there are several options.[25]

A life care planner could be hired to determine an estimate of the amount of future medical care that an injured party may require. The up-side of this option is that this life care plan would not need to be submitted to CMS for approval, since it is not technically an MSA. Since this option does not require a submission to CMS, it also does not delay settlement. The down-side is that it does, however, involve the expense of hiring a life care planner to determine all medical care required. Additionally, a life care planner will probably only be able to determine all medical expenses (Medicare or otherwise) on behalf of a Medicare beneficiary, and will probably not be able to separate out just the expenses that are attributable to Medicare. This may cost the primary payer more in the long run.

Another option is to request and obtain an MSA from an MSA vendor or other MSA professional. The benefits of this option are that it is actually approved by CMS, and, therefore, should not be subject to being overturned at a later date, should CMS create guidelines that are in conflict with the terms of the non CMS-approved MSA. Also an MSA vendor could limit his projection for future medicals to only those costs that would otherwise be covered by Medicare. Because it requires CMS approval, however, this could delay settlement.

Whichever option is chosen, if it is determined that Medicare's future interests are going to be considered in a settlement agreement, certain specific provisions should be included in that settlement agreement so that it is clear that **the funds designated for future medical care are clearly identified in the settlement agreement and that the injured party is placed on notice of the intended purpose of those funds.** The settlement agreement needs clear and concise language reflecting that Medicare's interests have been taken into account.

If you have questions or concerns about how the Medicare Secondary Payer Statute or the Medicare Set Aside rules may affect your organization's obligation to CMS or a Medicare beneficiary, please feel free to contact Chris Allman at callman@ottenwesslaw.com or 313-965-2121 x 212.

End Notes

1. 42 U.S.C. § 1395y(2)(A).

2. *See* 42 C.F.R. § 411.50.

3. *See* 42 C.F.R. § 411.21.

4. 42 U.S.C. §1395y(b)(2)(A)(ii).

5. 42 U.S.C. § 1395y(b)(2)(B)(I).

6. 42 U.S.C. § 1395y(b)(2)(B)(ii).

7. 42 C.F.R. § 411.21.

8. 42 U.S.C. § 1395y(b)(2)(B)(ii).

9. 42 C.F.R. § 411.24(g).

10. 42 C.F.R. § 411.24(c)(i)(ii).

11. 42 U.S.C. § 1395y(b)(2)(B)(ii), 42 C.F.R. § 411.24(c)(2).

12. 42 C.F.R. § 411.26.

13. 42 U.S.C. § 1395y(b)(2)(B)(ii).

14. 42 U.S.C. § 1395y(b)(2)(B)(ii).

15. 42 C.F.R.§ 411.25(a).

16. 42 C.F.R.§ 411.25(a).

17. Group Health Plans (GHP) are actually treated completely separately under Senate Bill 2499 and are not considered here.

18. Senate Bill 2499, Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), (Public Law 110-173), Section 111(a)(8)(F). These requirements apply to workers' compensation, liability insurance (including self-insurance), and no-fault insurance, and includes "the fiduciary or administrator for such law, plan or arrangement."

19. MMSEA, Section 111(a)(8)(B).

20. MMSEA, Section 111(a)(8)(C).

21. MMSEA, Section 111(a)(8)(E)(i).

22. Popolizio, Mark J., J.D., "Liability Cases & Medicare Compliance," Page 3, June 2008.

23. *See* CMS Alert 2/23/09 and Transcript of CMS Town Hall Teleconference on Section 111 Requirements, March 24, 2009, Page 24.

24. Meifert, Patty & Lewis, Robert. "Considering Medicare's Interests in Liability Cases: Will the Real Expert Please Stand Up," Page 4, August 31, 2005.

25. Of course, given CMS's lack of guidance on the issue, there is no guarantee that either of these options will suffice. However, they seem to reasonably satisfy Medicare's indication that their future interests should be taken into account.