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PROTECTING INSURANCE COMPANY AND DEFENSE FIRM INTERESTS UNDER THE MEDICARE SECONDARY PAYER ACT

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I. INTRODUCTION

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) reinforces 42 U.S.C. §1395y, known as the Medicare Secondary Payor (MSP) statute. The new Act provides the Secretary of Health and Human Services with authority to ensure that group health care plans, no-fault policies, workers' compensation claims and liability settlements protect Medicare's interests by remaining the primary payment source of Medicare-covered expenses. The MSP has existed in some form since the inception of the Medicare program in 1965. It was amended when the Medicare, Medicaid, & SCHIP Extension Act of 2007 (MMSEA) imposed significant reporting requirements on workers' compensation, liability and no-fault plans (including self-insured plans). Section 111 of the act amends section (b) of the MSP by requiring insurers to identify instances where they are primary to Medicare and must report that information to the Secretary of Health and Human Services. Group health plans, workers' comp, liability, self-insured and no-fault carriers must report claims in which the injured party is entitled to Medicare. Liability, self-insured and no-fault carriers must report their primary status upon settlement of a disputed claim.

The Secretary is granted substantial power to collect conditional payments of Medicare benefits from primary liability insurers. This authority has given Medicare substantial powers to collect from any party in a liability settlement including Medicare beneficiaries, the tortfeasors, insurers and attorneys. Thus, defense attorneys need to understand MMSEA regulations and what steps they can take to protect themselves, their clients and their clients' liability insurers from government/collection actions.

II. STATUTORY AUTHORITY AND ENFORCEMENT BY THE COURTS

With the passage of MMSEA, the Centers for Medicare and Medicaid Services (CMS), a division of the Department of Health and Human Services (HHS), is in the process of creating new rules that will enable them to better identify entities that fail to protect Medicare's interests. Failure to comply can result in the assessment of a double damage penalty. The penalty may be assessed against one or more parties to a settlement, including the attorneys involved. Thus the government has been granted broad statutory authority to enforce its collection rights where conditional payments have been made. This broad authority has been applied and affirmed by the Federal District Court for the Northern District of West Virginia.

A. Statutory Authority

Medicare is a secondary insurance plan that conditionally pays for medical treatment subject to reimbursement by a primary source such as private health insurance or a third-party tortfeasor. A Medicare beneficiary who receives payment from a primary source must reimburse Medicare within 60 days. Medicare's right to reimbursement trumps everything else, even if a client's recovery has already been distributed[1].

Enforcement of reimbursement rights rests with the Centers for Medicare and Medicaid Services. CMS can seek reimbursement directly from the Medicare beneficiary and from anyone else who receives payment from the primary source including an attorney.[2] A key amendment to the MMSEA, commonly known as "section 111," is specifically interpreted as a requirement on defendants to determine whether a plaintiff is a Medicare beneficiary. Defendants and their

[1] 42 U.S.C. § 1395y(b)(2)(B); 42 C.F.R. § 411.24(h)
[2] 42 U.S.C. § 1395y(b)(2)(B); 42 C.F.R. § 411.24(g)

counsel must notify Medicare of the pending litigation and the plaintiff's identity if they discover the plaintiff is a Medicare beneficiary.[3]

Section 111 specifically adds 42 U.S.C. §1395y(b)(8) to the MSP which imposes strict information reporting requirements on liability insurance plans, no-fault insurance plans and worker's compensation plans, (including self-insurance), referred to collectively as "Required Reporting Entities" or "RREs". According to Section 111, RREs have the responsibility to: (1) determine whether a plaintiff/claimant is entitled to Medicare benefits on any basis; and, (2) upon settlement of a Medicare beneficiary's claim, submit all information required by CMS with respect to the claimant to CMS. RREs will be required to submit required information on a quarterly basis. Penalties for non-compliance are stiff: $1,000 per claimant for each day that the RRE is out of compliance. This penalty is in addition to any Medicare Secondary Payer claim for which the plan, as primary payer, may be liable.

The Secretary of Health and Human Services has statutory priority to recover any and all conditional payments from a claimant, the insurer, the attorneys or any other party. The Secretary may make payment with respect to an item or service if a primary plan has not made or cannot reasonably be expected to make payment with respect to such item or service promptly.[4] Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund. The Secretary has the right to charge interest if not reimbursed for conditional payments within 60 days of notification from CMS.[5] The government may bring action against ANY and ALL that are responsible for payment (insurer, insured, attorney, employer, etc.) or received payment from the primary payer & has statutory right to double recovery. Specifically,

[3] *See* 42 U.S.C. § 1395y(b)(7) and (8)); 42 C.F.R. §§ 411.22–411.25
[4] 42 U.S.C. 1395y(b)(2)(B)(i) – Grants Authority to make "Conditional Payments"
[5] 42 U.S.C. 1395y(b)(2)(B)(ii) – Right to Interest

the government my recover from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.[6]

It is important to note that Medicare, through CMS, asserts a statutory claim as opposed to a lien. Liens typically attach to a settlement and are the responsibility of the claimant or plaintiff to respond to and satisfy from settlement proceeds. In addition, in most jurisdictions, lien holders are required to place the claimant or plaintiff on notice of their lien interests. This is not the case where Medicare is concerned. By statute, Medicare is not required to place any party to the settlement on notice of their interests in the claim or settlement. In fact, insurers or self-insured parties to the claim or settlement must place CMS on notice through the mandatory reporting mechanism. Claims that are denied or disputed do not require reporting until such a time as the claim is accepted or settled.

B. Enforcement of Recovery Rights Against Attorneys

To date, the seminal case that should concern all attorneys regarding the Government's collection rights being enforced occurred in *US v. Harris*[7] in the United States District Court for the Northern District of West Virginia. In this case, an underlying personal injury plaintiff's attorney was held responsible for reimbursement of conditional payments made by CMS. The Government filed a complaint against the plaintiff's attorney, seeking to assert its recovery rights under the MSP. The plaintiff in the underlying litigation was a Medicare beneficiary who suffered physical injuries. CMS made a conditional payment of approximately $22,549.67 in Medicare claims to the underlying plaintiff/beneficiary. The underlying case ultimately settled for $25,000.00, and Medicare agreed to reduce its conditional payments to $10,253.59 based upon attorney fees, costs, and the amount of the settlement.

[6] 42 U.S.C. 1395y(b)(2)(B)(iii) – Action by the United States to recover payment
[7] 2009 WL 891931 (N.D.W.Va. 2009)

CMS subsequently sent a letter to Counsel informing him of the decision and advised that if his client disagreed with the amount of payment that an appeal had to be filed within 120 days of receipt of CMS's letter. Counsel never filed any such appeal and also failed to reimburse CMS within the statutorily required 60-day time period. The Government filed suit against the attorney alleging it was entitled to its calculated share of the settlement plus interest. The Government sought total payment of $11,367.78 plus interest from the attorney. Summary judgment was granted in favor of the Government stating that the MSP provided that the Government may recover from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.[8] The Court also cited to federal regulations which state that "CMS has a right of action to recover its payments from any entity, including a beneficiary provider, supplier, physician, attorney, state agency, or private insurer that has received primary payment."[9] The Court held that this plaintiff's attorney was individually liable for reimbursing Medicare because 42 C.F.R. § 411.24(g) allows the Government to recover "from any entity." This decision clearly shows CMS's broad recovery rights under the MSP. Accordingly, any party or party representative that participates in the litigation or the settlement of a Medicare beneficiary's claim must take every precaution to ensure that Medicare's interests are protected.

III. PROTECTING DEFENSE ATTORNEY'S, THEIR CLIENTS AND INSURERS FROM GOVERNMENT COLLECTION EFFORTS

Defense attorneys will need to protect themselves as well as their clients and their liability insurers. Liability insurance differs from other plans (i.e. no fault insurance, group health plans, workers comp, etc.) because liability insurance has a contractual obligation to

[8] 42 U.S.C. § 1395(b)(2)(B)(ii)
[9] 42 C.F.R. § 411.24(g)

compensate the alleged tortfeasor for any damages the alleged tortfeasor must pay to an injured party. In MSP liability situations, overpayment to a Medicare beneficiary does not exist before a settlement is reached between the beneficiaries and the liable party or a court renders a judgment. Medicare's claim only comes into existence by operation of law when payment for medical expenses that Medicare conditionally paid for has been made by a third-party payer.

It is common for insurance companies to settle claims without admitting liability. Therefore, any payment by a liability insurer, constitutes a liability insurance payment whether there has been a determination of liability. Regardless of how amounts may be designed in a liability award or settlement (e.g. loss of consortium, special damages or pain and suffering), Medicare is entitled to be reimbursed for its payments from the proceeds of the award or settlement. If a negligent party who carries liability insurance decides to pay a liability claim with his/her own funds rather than submit the claim to the liability insurer, Medicare still recovers its benefits for such a payment because it is deemed to be a liability insurance payment.

A. Use of Discovery and Settlement Agreements to Protect the Attorney, Insurer and Client

Defendants who make payments to plaintiffs around a Medicare claim are playing with fire; they could end up paying twice. The regulations provide that the defendant or its insurance company must reimburse Medicare "even though it has already reimbursed the beneficiary or other party."[10] To avoid such sanctions, Defense counsel should conduct prompt discovery to ascertain whether the plaintiff is a Medicare beneficiary, and if so the extent of benefits received.

Interrogatories should be served requesting the plaintiff to state whether or not he/she was eligible to receive Medicare benefits. If benefits were received, the plaintiff should be

[10] 42 C.F.R. § 411.24(i)

requested to state: the name of the treating physician; the date upon which services were provided; a description of the service; and, the amount Medicare has paid or been asked to pay. Also, included in the requests for production of documents should be a request for an executed consent to release authorizing CMS to release to defense counsel information regarding injuries suffered by a claimant/plaintiff as a result of the alleged conduct of the defendant.

Futhermore, if Medicare's claim is unresolved, settlement may be difficult. Defendants will no doubt insist on including language in the settlement agreement that makes the plaintiff (and plaintiff's counsel) responsible for all liens, including Medicare. The defense will probably ask for indemnity with respect to those liens, and may condition final payment upon resolution of them, perhaps with Medicare as a co-payee on the settlement draft. Defendants can may also interplead settlement funds and join Medicare as a party so that everyone can conclude outstanding issues in a single proceeding. When handling settlement proceeds, attorneys should set aside sufficient funds in their trust account to cover a potential Medicare claim. Clients may not like having their money tied up, but doing so avoids future liability.

Many parties assume that inserting indemnity and hold harmless terms into settlement documents will protect the defendant/insurer from Medicare's statutory claim. However, Medicare is not a party to the settlement and, therefore, is not bound by the terms of the settlement or any associated settlement documents. They have not been involved in negotiations and have not waived any of their statutory rights against all parties to the settlement. If Medicare's interests have not been protected, as required by federal statute, they may commence a collection action against any and/or all parties to the settlement, including the involved attorneys. State laws or judicial orders will not trump Medicare's federal entitlements.

B. Medicare Set-aside Allocations

Insurers and defense attorneys need to be especially cautious in situations where a claimant/plaintiff will require future medical treatment for injuries sustained as a result of the alleged conduct of the tortfeasor. The Medicare Secondary Payer statute states:

> Payment under [Medicare] may not be made . . . with respect to any item or service to the extent that. . .
>
> > (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.[11]

CMS interprets this language as providing that any settlement that closes out future medical expenses in a claim against a primary payer represents a situation in which payment has been made for an item or service otherwise covered by Medicare, precluding future Medicare coverage for those items or services until the payment has been exhausted on future medical expenses related to the injury. This provision of the Secondary Payer Statute gave rise to the use of first Medicare Set-Aside Arrangement (MSA) in a workers' compensation settlement in 1995. This same provision also forms the basis for statements from CMS that Medicare's interests as secondary payer must be reasonably considered in liability settlements. As a result, the use of MSAs in liability settlements is becoming more and more common.

MSA's are arrangements made between the settling parties in order to protect Medicare's interests when settling future medical benefits for individuals who are or will become, entitled to Medicare and prevent the shift of that burden from the primary payer to Medicare. CMS thresholds DO NOT provide safe harbors where MSA's are not required. MSA's are necessary

[11] 42 U.S.C. §1395y(b)(2)(A)(ii)

whenever there is foreseeable, ongoing medical treatment, related to the insurance claim being settled, required at any time in the future where the injured party will be eligible for Medicare.

The amount of the set aside is basically a guessing game that should reflect a reasonable projection of future medical costs related to the injury/illness that would otherwise be covered by Medicare. These are not life care plans and are not needed where medical benefits remain open. The set aside may also not be needed if there is no need for future treatment or future treatment is NOT covered by Medicare. However, if it is determined that future Medicare covered treatment will be needed, calculate the amount to set aside at the State/Medicare fee schedule or usual & customary price. Factors to be considered are: the life expectancy of the claimant; Medicare covered services related to the claim; state fee schedule as opposed to the usual and customary pricing for medical services; inflation; professional administration fees; and, lump sum payments as opposed to annuity funding.

Defense attorneys should also consider the benefit of a claimant administered set-aside fund as opposed to a professionally administered set-aside fund. Administrative responsibilities may be placed on the claimants themselves. The funds can be placed in interest baring account separate from any personal account. The claimant will be responsible for making payments at the rate used to calculate the funds in the MSA. The payments can only be made for Medicare covered services related to the covered injury. Furthermore, the claimant will be responsible for keeping an adequate accounting that can be reviewed by CMS at anytime and annual affirmation states will need to be submitted. The other option is to allow for a professional administration of the MSA. Annual fees for professional administration generally range from $500 to $2,000. This is likely to be more effective because it will most likely guarantee compliance with CMS policies

IV. CONCLUSION

The MMSEA grants the government a broad range of power to collect payments for conditional payments by Medicare. Given the ongoing economic crisis, Medicare will probably increase efforts to enforce its rights in personal injury cases. For that reason, defense attorneys need to be aware of both Medicare's notification and reimbursement rights and the consequences of ignoring them.