

MMSEA & The MSP– Confusion Reigns Supreme

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Passage of Section 111 of the Medicare, Medicaid & SCHIP Extension Act in 2007 (“MMSEA”) and its reporting deadline of 7/1/09 has caused a tremendous amount of confusion among insurance professionals, lawyers and settlement planners alike. As a result of the MMSEA new discovery is being sought to assist insurers in complying with the reporting requirements. While the new discovery is proper, some changes attributed to the MMSEA are completely inaccurate. For example, some insurers are insisting on putting Medicare on the check claiming the “new law” requires it. Another example is the insistence by some insurers that Medicare Set Asides are now required in all liability cases. Neither is true. The simple fact is that the MMSEA imposes a mandatory insurer reporting requirement upon responsible reporting entities (“RREs”). CMS has created a 224 page manual explaining what is required and defining terms used in the MMSEA. A discussion of all of the aspects of the MMSEA is beyond the scope of this article. I will delve into the MMSEA briefly to explain what it is and what is required, but the focus of this article is what it does not require in an attempt to clear up widespread misconceptions.

Section 111 of the MMSEA

First, what is the MMSEA and what does it require. On December 29th of 2007, President Bush signed into law the Medicare, Medicaid, and SCHIP Extension Act of 2007 (“MMSEA”).¹ The purpose of this legislation (specifically Section 111), as expressed by its sponsor Chuck Grassley (R – IA), is to

“[C]ontinue to improve accountability in the Medicare Program. There are situations when Medicare is not the primary payer for a beneficiary’s health care, but it is currently difficult to identify these situations. This legislation will improve the Secretary’s ability to identify beneficiaries for whom Medicare is the secondary payer by requiring group health plans and liability insurers to submit data to the Secretary.”²

Part of this Act, Section 111, extends the government's ability to enforce the Medicare Secondary Payer Act.³ As of July 1, 2009, an applicable plan, also known as an RRE, (liability insurer, self insurer, no-fault insurer and workers' compensation carriers) shall determine whether a claimant is a Medicare beneficiary ("entitled") and if so provide certain information to the Secretary of Health and Human (hereinafter "Secretary") Services when the claim is resolved.⁴

Under MMSEA, the RREs/insurers (hereinafter RRE) described above, must report the identity of the Medicare beneficiary to the Secretary and such other information as the Secretary deems appropriate to make a determination concerning coordination of benefits, including any applicable recovery of claim.⁵ Failure of an applicable plan to comply with these new requirements will incur a **civil money penalty of \$1000 for each day of noncompliance** with respect to each claim.⁶ A single claimant can have more than one claim but the penalty is per claim. These new reporting requirements will make it very easy for CMS to review settlements to determine whether Medicare's interests were adequately addressed by the settling parties.

Section 111 and Resulting New Discovery Requests

As a result of the MMSEA and RREs fear of not reporting promptly and being subjected to fines, many insurers are propounding discovery aimed at securing information to comply with the reporting. The RREs are requesting a Social Security number in order to verify whether a claimant is Medicare eligible. According to CMS, RREs may "submit a query to the COBC to determine Medicare status of the injured party prior to submitting claim information for Section 111 reporting." The query process is designed to assist RREs in determining whether the claim must be reported or not. The query must contain the client's SSN or Medicare Health Insurance Claim Number (HICN), name, date of birth and gender of the injured party. CMS created a sample form for insurers to use, in addition to discovery requests, to get basic information about the injury victim for the query system. The form requests all of

the information required by the query system. However, it also contains the following troublesome statement

“[f]or the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.”

The COBC, upon submission of the information outlined above will respond and indicate whether the individual is a Medicare beneficiary. If the injured party is a Medicare beneficiary, the HICN and other information found in the Medicare Beneficiary Database will be provided to the RRE. This process is done electronically with HEW (HIPAA Eligibility Wrapper) software provided by CMS, but the RRE must have the SSN or HICN. This is the reason why the new discovery requests are being implemented and why CMS created this new form.

MMSEA and Conditional Payments

As Senator Grassley indicated, the intent of the new reporting requirements was to identify situations where Medicare should not be the primary payer and ultimately allow recovery of conditional payments. The Medicare Secondary Payer Act (MSP) prohibits Medicare from making payments if payment has been made or is reasonably expected to be made by a workers' compensation plan, liability insurance, no fault insurance or a group health plan. However, Medicare may make a “conditional payment” if one of the aforementioned primary plans does not pay or can't be expected to be paid promptly. 42 U.S.C. § 1395y (2007). These “conditional payments” are made subject to being repaid when the primary payer pays. When conditional payments are made by Medicare, the government has a right of recovery against the settlement proceeds.

Congress has given the Centers for Medicare and Medicaid Services (CMS) both subrogation rights and the right to bring an independent cause of action to recover its conditional payment from

“any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service (or any portion thereof) under a primary plan.” 42 U.S.C. § 1395y (2007).

Furthermore, CMS is authorized under federal law to bring actions against “any other entity that has received payment from a primary plan.” Most ominously, the government may seek to recover double damages via an independent cause of action.

US v. Harris - A Trial Lawyer’s Worst Nightmare

The government takes its reimbursement right seriously and is willing to pursue trial lawyers who ignore Medicare’s interest. In U.S. v. Harris, a November 2008 opinion, a personal injury plaintiff lawyer lost his motion to dismiss against the U.S. Government in a suit involving the failure to satisfy a Medicare subrogation claim. The plaintiff, the United States of America, filed for declaratory judgment and money damages against the personal injury attorney owed to the Centers for Medicare and Medicaid Services by virtue of 3rd party payments made to a Medicare beneficiary.

The personal injury attorney had settled a claim for a Medicare beneficiary (James Ritchea) for \$25,000. Medicare had made conditional payments in the amount of \$22,549.67. After settlement, plaintiff counsel sent Medicare the details of the settlement and Medicare calculated they were owed approximately \$10,253.59 out of the \$25,000. Plaintiff counsel failed to pay this amount and the Government filed suit.

The motion to dismiss was denied by the United States District Court for the Northern District of West Virginia despite plaintiff counsel’s arguments that he had no personal liability. Plaintiff counsel argued that he could not be held liable individually under 42 U.S.C. 1395y(b)(2) because he forwarded the details of the settlement to the government and thus the settlement funds were distributed to his clients with the government's knowledge and consent. The court disagreed. The court pointed out that

the government may under 42 U.S.C. 1395y(b)(2)(B)(iii) "recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity." Further, the court pointed to the federal regulations implementing the MSPS which state that CMS has a right of action to recover its payments from any entity including an attorney. See 42 C.F.R. 411.24 (g).

Subsequently, the U.S. Government filed a motion for summary judgment against plaintiff counsel. The United States District Court, in March of 2009, granted the motion for summary judgment against plaintiff counsel and held the Government was entitled to a judgment in the amount of \$11,367.78 plus interest. Plaintiff counsel distributed the settlement funds to the client so the Court found the attorney was responsible to pay the judgment. This opinion clearly signals the intent of CMS to go after attorneys for money it feels it is entitled to under the Medicare Secondary Payer Act. Section 111 of the Medicare, Medicaid, SCHIP Extension Act ("MMSEA") will now make it very easy for CMS to discover situations such as this one and take action against anyone who touches the money.

Medicare on the Settlement Check

Most trial lawyers understand their obligations under the MSP with regard to making sure conditional payments are repaid. The problem is the growing misconception among insurers that Medicare should be on the settlement check to insure compliance with the MSP. Some insurers have even been told that the law requires Medicare be on the check. This is simply not so.

I have personal experience with this particular issue as I was involved in litigation over whether Medicare must be on the settlement check. I was asked last year by a trial lawyer to assist in a case where Medicare was put on the check despite this not being a term of settlement. The insurer moved to enforce the settlement and plaintiff counsel was forced to defend his position that the law didn't

require Medicare be on the check resulting in no settlement at all. I provided an affidavit arguing the law did not require Medicare be on the check. That case resulted in a published opinion, Tomlinson v. Landers, regarding the issue of whether Medicare must be on the check.

My affidavit made the argument that Medicare was not required to be on the checks. The following is an outline of the argument. Despite the liability for defendants and their insurers as it relates to Medicare liens, the common practice when settling a case involving a Medicare beneficiary is for the settlement draft to be made payable to the injury victim and the personal injury lawyer's trust account. Within the settlement agreement, the injury victim will typically agree to hold the defendant and its insurer harmless and indemnify them regarding any conditional payment obligations.

Putting Medicare on the settlement check as a payee, is not common practice and is ill advised. There is no legal requirement under the MSP that Medicare be put on a settlement check as a payee. Putting Medicare on the check can cause injury and harm to plaintiffs in terms of their legal right to negotiate the conditional payment obligation. As a starting point, Medicare should not be on the settlement check because they are not a party to the lawsuit. Medicare does not request that they be put on the check and are not part of the settlement negotiations. Further, Medicare may not be entitled to their full conditional payment amount and there is a formula for reduction. In addition, there are frequently items in the detail of the billing that are unrelated to the care for the injury which must be removed. Most importantly it prevents a possible waiver.⁷ In certain cases, Medicare will waive a conditional payment entirely. Having Medicare on the check prevents the plaintiff from negotiating the conditional payment amount or potentially getting a waiver.

Further, it is impractical to have a settlement check that has Medicare as a payee. The check can't be negotiated. The check would have to be signed by the injury victim and plaintiff counsel and then sent to the Medicare Coordination of Benefits Office. The question is who at Medicare would sign

that check? How would the conditional payment satisfaction process go? How would the refund back to the injury victim and his lawyer be processed? How long would it take for all of this to take place? What happens if the check is lost? Having Medicare included as a payee causes a lot of issues to arise and unanswered questions to develop.

The problems created by having a settlement check with Medicare listed as payee is demonstrated by the MSPRC's standard letter to injury victims. These letters typically request that the injury victim or his attorney "refrain from sending any monies to Medicare prior to submission of settlement information and receipt of a demand/recovery calculation letter from our office." The reason for this according to the letter is that it "will eliminate underpayments, overpayments, and/or associated delays." Medicare is specifically saying that settlement proceeds should not be sent to them until the final demand is made by them because it could result in overpayment and delays. This letter is a standard letter used by MSPRC and reflects their policy regarding procedurally how to deal with repayment of conditional payments. Medicare will also return checks when they are asked to endorse them.

It is well established that the MSPRC is slow in getting information regarding conditional payments to personal injury victims and their counsel. It can take a substantial amount of time, sometimes measured in years to obtain the Medicare verification of conditional payment amount. As the MSPRC acknowledges, simply sending in a settlement check without determination of the conditional payment obligation can result in overpayment and delay. In addition, sending a settlement check to Medicare that includes payment for injuries suffered as well as attorney fees and costs would deprive the injury victim of the use of funds that are not subject to a claim by Medicare. It would also deprive the injury victim of the ability to negotiate the conditional payment obligation as Medicare can simply deduct what it wants from the check.

Given the exposure to double damages a personal injury plaintiff lawyer faces for failure to repay a Medicare conditional payment and the fact that the defendant can insist upon a hold harmless and indemnification agreement, it is unnecessary to put Medicare on a settlement check. It is my experience that personal injury plaintiff lawyers generally understand the laws as they relate to Medicare reimbursement and most repay those conditional payments given their exposure to double damages for failure to reimburse Medicare. Accordingly, it is unnecessary for Medicare to be included on the check in circumstances such as this.

In *Tomlinson v. Landers*, the court found definitively that the MSP didn't require Medicare be on the check. The court stated that "federal law does not mandate that a primary payer (or insurer) make payment directly to Medicare." The court did recognize though that "an insurer may be liable to Medicare if the beneficiary/payee does not reimburse Medicare for any amounts owed to Medicare within sixty (60) days." Nevertheless, the court found the defendant's decision to "list Medicare as a payee on the settlement check may have been in [defendant's] . . . best interest, however, [defendant] . . . was not required by federal to include Medicare on the settlement check." Given this fact and the dispute concerning whether Medicare needed to be included on the check illustrated to the court there was no meeting of the minds in terms of settlement. As a result, the settlement was not enforced and a bad faith action could be pursued. When an insurer takes a similar position in the future, it may open the door to similar holdings and bad faith causes of action.

Medicare Set Asides in Liability Settlements

While "Medicare on the check" is a very problematic issue, a larger issue is the alleged connection between Medicare Set Asides and the MMSEA. A brief explanation of Medicare Set Asides is in order before addressing the impact of MMSEA on Medicare Set Asides. A client who is a current Medicare beneficiary or reasonably expected to become one within 30 months should concern every

trial lawyer because of the implications of the MSP. Medicare Set Asides are a device approved by CMS for protecting Medicare's interests under the MSP. An MSA is a portion of settlement proceeds set aside, called an "allocation," to pay for future Medicare-covered services that must be exhausted prior to Medicare paying for any future care related to the injury. The amount of the set aside ("allocation") is determined on a case-by-case basis and may be submitted to CMS for approval if the case fits within the review thresholds established by CMS. A detailed discussion of Medicare Set Asides is well beyond the scope of this article.

CMS has made it very clear in numerous conference calls that the MMSEA is totally unrelated to Medicare Set Asides. CMS has been holding a series of telephone conferences with insurers about the MMSEA mandatory insurer reporting requirements. In one such conference call, Barbara Wright, acting director of the Medicare debt management division at CMS, stated that Section 111 of the MMSEA "does not mandate or specify anything about liability set asides." It can't be made any clearer than that. There is no relationship between MMSEA and Medicare Set Asides in liability cases. However, Barbara Wright did say in that same teleconference "we have a very informal, limited process for liability set asides." She acknowledged they didn't have the "extensive" rules or procedures like the "ones [they] . . . have for workers' comp." Finally, she indicated that "CMS approval of a set aside amount is not required. It is a voluntary process".

Each regional office sets its own policy on whether to review liability set asides despite Barbara Wright's comments. Out of the 10 regional offices informally surveyed, two will not review (Boston and San Francisco). Yet the San Francisco Regional office made a formal pronouncement regarding liability set asides. According to Thomas S. Bosserman, Health Insurance Specialist for Centers for Medicare and Medicaid Services in the San Francisco Regional Office, the following statement is a "formal iteration of longstanding CMS policy concerning Liability insurance settlements and future medicals."

The Centers for Medicare & Medicaid Services (CMS) has no current plans for a formal process for reviewing and approving Liability Medicare set-aside arrangements. However, even though no formal process exists, there is an obligation to inform CMS when future medicals were a consideration in reaching the Liability settlement, judgment, or award as well as any instances where a Liability settlement, judgment, or award specifically provides for medicals in general or future medicals.

The question becomes what to do when faced with an insurer who insists on a Medicare Set Aside in a liability case. A trial lawyer could ask for the insurer's legal basis for mandating a Medicare Set Aside in a liability case. You can ask for a cite to the federal statutes, code of federal regulations, case law or any rules/process regarding Medicare Set Asides for liability cases. There are currently none, no one will find any law that directly addresses the issue of Medicare Set Asides for liability cases. However, I am not advocating ignoring Medicare's interest under the Medicare Secondary Payer Act. To adequately protect yourself and a client who is a Medicare beneficiary or reasonably expected⁸ to become a Medicare beneficiary within 30 months of settlement, a Medicare Set Aside evaluation may be in order. As described below, this is a voluntary process and CMS may not review the proposed set aside.

A trial lawyer may want to take the position that the insurer should bear the costs of the MSA evaluation and costs of the set aside (including professional administration of the account). In addition, there are many non-Medicare medical expenses that must be considered in arriving at a settlement for future medical costs (i.e., certain durable medical goods, custodial care, certain prescription medications and the Part D donut hole to name a few). If a set aside will be established, a thorough examination of non-Medicare expenses along with an allocation of future Medicare covered future services should be undertaken. There are other options besides a formal set aside if a trial lawyer is faced with an insurer who requires addressing Medicare's interest.

One option is to estimate the future Medicare covered expenses the client will potentially incur and document that amount in the settlement agreement. The estimate can be created from doctors reports or life care plans. The client then sets aside this amount and is told to use it for future Medicare covered expenses. No submission to CMS is done if this option is exercised. However, the release provides evidence that Medicare's interests were taken into account at settlement. Since CMS admits there is no formal review process for liability settlements and submission is voluntary, an argument can be made that all the current law requires has been done and then some.

Another option is to do the formal allocation report and again document it just like was mentioned in the foregoing paragraph. Since CMS does not guarantee a review of a liability set aside, a formal allocation along with documenting it in the settlement agreement provides the necessary evidence that Medicare's interest were adequately addressed. A formal allocation also gives the trial attorney a third party who is independent to review the future medical expenses and determine what is Medicare covered and what is not. This is an important piece of protection for the trial attorney as it provides an extra layer of E&O protection.

Conclusion

It is this author's opinion that Medicare protocols and procedures regarding the repayment of conditional payments should not change due to MMSEA. However, insurers' behavior will and has most certainly changed. Insurance companies are fearful of all the reporting requirements under MMSEA because failure to comply is a \$1,000 per day, per claimant fine. For a large insurer, that is significant exposure. Therefore, new discovery has been created to help insurers comply. Medicare may be put on the settlement check and unfortunately some insurers are insisting on Medicare Set Asides in liability cases. Each trial lawyer and law firm will have to interpret the MSP laws and deal with the insurers on

these issues to protect the client as well as their practices. There are many unanswered questions with little clarity or law to help guide trial lawyers.

¹ Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173). This Act was passed by the House on December 19, 2007, and by a voice vote in the Senate on December 18, 2007.

² Congressional Record, U.S. Senate, December 18, 2007, S15835, paragraph 9.

³ Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173).

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ See 42 U.S.C. 1395gg(c) and 42 C.F.R. 405.355-405.356 and 405.358

⁸ Reasonable expectation is defined as an individual that has applied for Social Security Disability Insurance (“SSDI”) benefits; has been denied SSDI but anticipates appealing that decision; is in the process of appealing and/or refiling for SSDI; is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or has End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.