

## **The Medicare Secondary Payer Act and Its Impact on Litigation**

The Medicare Secondary Payer Act (the “MSP Act”) was first enacted in 1980; however, it is the recent Section 111 reporting requirements (that become effective January 1, 2011 for settlements entered into on or after October 1, 2010) that have brought that statute to the forefront of personal injury and insurance defense litigation. Because liability settlements that include Medicare beneficiaries now have to be reported to the Centers for Medicare and Medicaid Services (“CMS”), all parties must ensure that any settlement has satisfied the MSP Act’s requirements or risk penalties.

### **Overview**

Initially, the Medicare program was the primary payer for covered medical services furnished to its beneficiaries, with the exception of those who were also covered by workers’ compensation (“WC”), whether or not the beneficiary had any other insurance available. In an attempt to reduce spending and preserve the fiscal integrity of the Medicare program, Congress enacted the MSP Act, 42 U.S.C. § 1395y(b), which amended the Social Security Act to make Medicare the “secondary” payer in situations where a “primary plan” exists.

In addition to group health plans, “primary plans” are defined to include WC plans, automobile and liability insurance policies or plans (including self-insurance), and no-fault insurance plans, which are referred to as non-group health plans or “NGHPs.” Liability insurance includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance.

Thus, under the MSP Act, Medicare does not pay for medical services when payment has been made or can reasonably be expected to be made by a primary plan. Instead, Medicare becomes a “secondary payer” and is only responsible for paying the excess medical expenses, if and when the amount paid by the primary plan is exhausted.

The MSP Act itself was amended in 2007 as part of the Medicare, Medicaid, and SCHIP Extension Act (“MMSEA”). Notably, Section 111 of the MMSEA imposed new data collection and mandatory reporting requirements on insurers in an effort to provide CMS with greater tools to enforce the MSP Act. Section 111 also provides civil monetary penalties for noncompliance with the mandated reporting requirements.

#### Conditional Payments

Medicare will make conditional payments for Medicare covered services to a health care provider if the primary plan will not pay or will not pay promptly. Medicare must be repaid for these conditional payments by the primary payer or anyone who may have received proceeds from an insurance judgment or settlement if it is demonstrated that another payer had a responsibility to make a payment. Because Medicare must be reimbursed for conditional payments from the proceeds of the settlement, to negotiate effectively, the parties to the suit need to know the conditional payment amount.

#### Medicare’s Right of Recovery

CMS may initiate recovery of a conditional payment as soon as it learns that payment by the primary payer has been made or could be made. The primary insurer’s responsibility for payment may be demonstrated by a judgment; a payment conditioned on the recipient’s compromise, waiver, or release of payment for items or services included in a claim against the primary plan; or by a settlement, award, or other

contractual obligation, whether or not there is a determination or admission of liability. Thus, once an insurer becomes liable for payment of accident-related medical expenses CMS must be reimbursed for the conditional payments it previously made on the beneficiary's behalf.

The MSP Act gives the government significant enforcement tools. It has a direct priority right of action against primary plans and any entity that received a third party payment and, if successful, may recover double damages (this right of recovery continues to be referred to by many as a "Medicare lien"). Accordingly, the government could initiate recovery actions against persons and/or entities including a beneficiary, provider, supplier, physician, state agency or attorney that received any part of the proceeds of a payment from a primary plan. The government also has a subrogation right with respect to any third party payment. Thus, everyone involved in a MSP claim, including attorneys, has potential exposure for Medicare recovery. *See U.S. v. Stricker, et al.*, No. 09-2423 (N.D. Ala. Dec. 1, 2009).

Lastly, the MSP Act establishes a private right of action for damages against a primary plan that fails to provide primary payment or appropriate reimbursement of Medicare conditional payments. If the private litigant is successful in its action, it may also recover double damages.

#### Medicare's Future Interests/Workers' Compensation Guidance

Because a Medicare beneficiary could claim entitlement to Medicare benefits for future health care expenses related to the accident and/or injury at issue, Medicare's future interests must also be considered when a claimant receives a lump sum settlement. The process for protecting Medicare's interests in future benefits has been developed in

the WC context through a series of Regional Administrative Letters and Memoranda. While there is no comparable process for liability settlements, the WC guidance provides a useful method to evaluate whether Medicare's interests in future benefits have been adequately considered.

Medicare's future interests are to be considered at the time of settlement if: (1) the claimant is a Medicare beneficiary at the time of the settlement and the total amount of the settlement is greater than \$25,000 or (2) the claimant is not a Medicare beneficiary at the time of the settlement but has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date, and the anticipated total settlement for future medical expenses and disability/loss wages over the life or duration of the settlement agreement is expected to be greater than \$250,000.

The vehicle that has been developed to protect Medicare's future interests is called a "Medicare Set-Aside Agreement" ("MSA"). So long as the WC carrier follows the MSP rules in establishing a MSA and CMS approves the MSA, the WC carrier protects itself from having Medicare claim at a later time that its interests were not taken into account.

Although Medicare's interests must be considered in liability insurance settlements, the law is currently unsettled and no CMS guidance is available as to how this must be accomplished. MSAs are currently not explicitly required for liability insurance settlements, and there is no routine approval of liability insurance MSAs by CMS. Accordingly, without any clear guidance, litigators have been experimenting with different ways to consider Medicare's future interests for large settlements.

#### Section 111 Reporting

In an effort to help CMS enforce the MSP rules, the MMSEA added new mandatory reporting requirements to the MSP Act (“Section 111 Reporting”). The goal of the Section 111 Reporting was to enable CMS to more readily identify potential reimbursement claims in situations where Medicare beneficiaries received insurance settlements and/or awards. Section 111 places a duty on insurers to (1) determine if a claimant is entitled to Medicare and (2) notify Medicare of the claimant’s entitlement and such other information as specified by CMS. The information collected under Section 111 will be used by CMS to ensure that Medicare makes payment in the proper order (*i.e.*, secondary to primary plans) and pursues recovery actions as appropriate. The MMSEA also includes penalties of \$1,000 for each day of non-compliance with the reporting requirements.

*Who Must Report?*

CMS refers to the entities that must comply with Section 111 Reporting as “Responsible Reporting Entities” (“RREs”). NGHPs are subject to the Section 111 Reporting requirements.

*When is Reporting Required?*

A NGHP must report to Medicare when it has accepted responsibility on or after January 1, 2010 for ongoing payment of a Medicare beneficiary’s medical expenses (“ORM”) or entered into a settlement or becomes liable for an award or other judgment regarding a bodily injury claim that involves a Medicare beneficiary where medicals are claimed and/or released, or the settlement, judgment, award or other payment has the effect of releasing medicals on or after October 1, 2010.

*What must be reported?*

RREs must report the identity of a Medicare beneficiary whose illness, injury, incident, or accident was at issue as well as other specified information. RREs must electronically submit the requested information in a specific form and manner after a claim is addressed or resolved through a settlement, judgment, award, or other payment, regardless of whether or not there is a determination or admission of liability.

*Complying with the Section 111 Requirements*

Compliance with the Section 111 Reporting is a two-step process. The first step is to determine if the claimant is a Medicare beneficiary and the second step is to satisfy the Section 111 reporting requirements.

Determining whether a claimant is a Medicare beneficiary requires the collection of certain information including the claimant's name, date of birth, gender, Medicare Health Insurance Claim Number and Social Security Number as well as whether the claimant is on Social Security Disability, and/or has end stage renal disease. Once this information has been obtained, an RRE can electronically submit it to the CMS Coordination of Benefits Contractor ("COBC") to determine if the claimant is a Medicare beneficiary. If the claimant is a Medicare beneficiary, the claim must be reported at the outset of the litigation. If the claimant is not a Medicare beneficiary, the RRE must, throughout the life of the claim or lawsuit, continue to check to determine if the claimant has become a Medicare beneficiary. Once the COBC learns of a Medicare beneficiary's claim or lawsuit, it will electronically transmit the case to the Medicare Secondary Payer Recovery Contractor ("MSPRC"), which will begin the process of searching for any conditional payments that may have been made by Medicare on behalf of the beneficiary.

On May 25, 2010 CMS announced a new Direct Data Entry (“DDE”) reporting option for NGHPs. The DDE option is only available to “Small Reporters,” which is defined as RREs that submits 500 or fewer NGHP claim reports per calendar year. With the new DDE option, Small Reporters will be able to use the Coordination of Benefits Secure Website at [www.Section111.cms.hhs.gov](http://www.Section111.cms.hhs.gov) to manually enter and submit individual claim reports online instead of submitting an electronic file. Further, instead of having to submit reports within an assigned submission window as with the current system, Small Reporters will be able to submit claims information at any time within 45 days of the settlement or assumption of ORM.

#### Conclusion

The MSP Act has always required that Medicare conditional payments be repaid once a beneficiary receives proceeds from a liability settlement and that Medicare’s future interests be considered in the settlement. Now that such settlements must be reported, all parties to the litigation are incentivized to ensure that these requirements are met. A cooperative approach among the Medicare beneficiary, attorneys and the insurer(s) will limit risks to all.

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